

**THE ENCYCLOPEDIA  
OF MENTAL HEALTH**

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# The Encyclopedia of MENTAL HEALTH

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VOLUME I



THE ENCYCLOPEDIA OF MENTAL HEALTH

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## PUBLISHER'S STATEMENT

*The Encyclopedia of Mental Health* is designed to meet the great and growing public need for sound information on this vital subject presented in simple terms that the general reader can understand.

Each article has been written by an authority in his field, and each contributor has had complete freedom to express his views within the scope of this work. Although styling was guided by *Webster's Third New International Dictionary* (unabridged) and *A Manual of Style*, University of Chicago Press, each author was free to make any changes he desired.

Albert Deutsch was appointed Editor in Chief on August 25, 1960, and before his sudden death on June 18, 1961, he had prepared the basic outline for the work and selected most of the contributors.

We are deeply indebted to the Board of Consultants, each of whom has given help far beyond the call of duty, and to many others who have made major contributions both as authors and as advisers.

We are proud that we have followed the basic ideas and plans of Mr. Deutsch in the original Prospectus in which he wrote: "I am pleased to have been invited to edit *The Encyclopedia of Mental Health*. The publishers have assured me that they want a sound compendium on mental health that could provide useful, authoritative information for the general public, and this is what I intend to give them. I hope to enlist the best minds in the mental health field in this enterprise. I look forward, hopefully and eagerly, toward developing a cooperative venture resulting in a signal contribution to public knowledge about mental health."

FRANKLIN WATTS

## ACKNOWLEDGMENTS

This work owes much to the many who have helped. The idea for *The Encyclopedia of Mental Health* was first broached by Mr. Frank Satenstein, who in turn said it was suggested by his friend, Dr. John McDowell McKinney.

The next step was to make a survey of the field and get some idea as to how it should be prepared—its general scope and nature. Miss Dorothy Wilson found that there was a need for a freshly written, authoritative, and uninhibited work in the field, and wrote a brief outline.

Dr. Leo Rosten, who suggested that we follow the question and answer format, also expressed his enthusiasm for the idea.

Mr. Albert Deutsch was the universal choice to head the project, as he knew the field and had the respect and confidence of all. The Board of Consultants did a tremendous amount of work. At the time of Mr. Deutsch's sudden death, all volunteered to help in any way they could, and all did far more than required.

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We wish to thank the American Medical Association for permission to reprint the *Classification of Mental Disorders* taken from "Standard Nomenclature of Diseases and Operation," edited by Edward T. Thompson and Adaline C. Hayden, pages 105 through 112, which appears in our article *Classification of Mental Disorders* by Dr. Moses M. Frohlich.

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# THE ENCYCLOPEDIA OF MENTAL HEALTH



# INTRODUCTION

## OPTIMUM MENTAL HEALTH

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The words *mental health* have become household words in less than a quarter of a century. They have come to stand for a great variety of human aspirations: for the effort to restore to full and healthy functioning those who are mentally ill; for the effort to set up conditions in town, city, and country throughout the world which will help prevent mental illness; for the active pursuit of human aspiration toward the brotherhood of man and a peaceful world; for both the cooperation of all the human sciences in an effort to improve the all-round functioning of human beings and for that state of a human being where he can be said to be functioning with his full capabilities, mentally and physically.

This encyclopedia is designed to go into the home, to answer the questions of individual men and women who wish to know more about any of the aspects of life covered by the term *mental health*, as it concerns themselves or others, members of their own families or communities or the wider world. A glance at the table of contents will show how wide the range of possible questions is: what is the mental health aspect of *Dreams, Epilepsy, Schools, Sterility, Animal Psychology, Psychosurgery, or Psychotherapy*?

Thus, as a newspaper reader one may meet a word like *brainwashing*; as a friend one may hear that a friend has been diagnosed as *schizophrenic*; as a spouse an argument may hinge on the innate differences between men and women; as a parent one may be confronted with some way in which one's own child differs from others—is “gifted” or “retarded”; parents or parents-in-law may come to visit and one begins to wonder about *aging*; or one's child grows older and for the first time in one's adult life the word *puberty* takes on meaning. Brains may be something one takes for granted—some people are said to have them, others are described as living without them—obviously just a figure of

speech. Then suddenly, a friend has a car accident; was there any *brain damage*? An acute need to know develops in an area where the comfortable clichés of our idiomatic world—"He has brains"; "He is brainless"; "He acts as if he'd been dropped on his head"—no longer suffice.

But a further look at the table of contents and the curiously diverse ways in which sequences of topics occur, such as *Creativity, Crime and Mental Disorders, Culture and Personality, Fear, Frigidity, Genius*, simply serve to heighten the sense of what a complex topic this is. We are so accustomed to thinking in polar opposites—human beings are not only things, male or female, good or bad, but they are persons, sick or well, old or young, normal or abnormal. Categories that are as rigid and obvious as the anatomical differences between male and female blur all the fine nuances of behavior that make the sickest person like the healthiest in a great many respects, and bind everyday acts of the most humdrum life to the more striking and dramatic occurrences in the lives of the prophets and the saints, the great statesmen, or the man who has "lost his mind" and behaves in a way that seems completely bizarre. Yet in actuality all human beings show touches of genius, great areas of almost complete conformity with the accepted standards of their society, and moments when their hold on reality slips or is so distorted as to influence all their judgments.

The man who works as an employee of a big organization has moments when he thinks his boss is a demon who could be suitably rewarded only by an eternity of torture; at other times the same man becomes to him a kind and protecting parent. There are days when the humblest employee knows that he could run the whole show better than those who run it, and days when the boss, weighed down with great responsibility, feels that every decision he has ever made is wrong.

Mothers, tired from a long day with four young children, may, at the end of the day, feel like one of the more picturesque of the martyrs eaten by Roman lions and be horrified to find old, forgotten, cruel jokes cropping up in their minds; or feel so fatigued that their only solution is to go and lie face down on the bed and let the baby scream and scream; or suddenly, when one child asks a profound and searching question, feel that this child, this particular child, may indeed be born for strange and troubling things.

At any of these moments of doubt or despair, of ecstasy or fleeting madness or great hope, each of us, no matter how average and usual our responses seem, experiences something of the extremes of behavior which, if too much accentuated, threaten an individual's mental health.



*As one becomes accustomed, on the one hand, to relating the strains and hopes of everyday life to the world where individuals break down altogether because the strain is too great, as in battle, or after nursing a parent through a long illness and death, or under too great pressure on a job, and on the other hand, to recognizing the heights of endurance to which other human beings, or the same human beings at other times, have risen, the complexity of the whole idea becomes more understandable.*

Of course our understanding of physical health is slowly expanding also, so that we no longer think of physical health as simply "normal" functioning and the absence of symptoms, but instead as a pattern of behavior of a particular kind of organism, of a particular age and sex and constitution, with a particular heredity endowment, a particular life experience, and living currently in a special and defined environment.

Health is seen to be something very different for a growing child and an aging man, for a peasant in a remote Asian village who has never had any medical care and for an American who has had the benefit of medical examination and care since birth. The Asian villager may have a life expectancy of thirty-five years, the American may have one of sixty-five years; one has no teeth, one has teeth; one has been infected with malaria and roundworms and has established enough resistance to survive; the other has had his wisdom teeth pulled, his appendix and tonsils removed, a suspected cancer treated by radium, and has had a bout of mononucleosis (glandular fever). Both go to work every day, one on foot, the other usually by car; one bends his back in the hot sun for ten hours, the other works in a room from which the light of day and the air of the moment and all sound have been excluded. Which man is the healthier? Obviously there are no criteria that do not have to be related back to the different circumstances within which each man has been reared and within which he lives. Each may be compared with his fellow workers who undergo the same kinds of conditions; but to compare the American and the Asian with each other requires a formula so elaborate that it must wait upon far finer diagnostic tools and methods of programming computers than we have today.

And we were speaking of physical health for which there are already many exact ways of measuring such matters as blood pressure or responses to specific drugs. In the field of mental health, however, the whole matter is enormously more complicated right from the start. The

outside environment is no longer a matter of heat and cold and humidity, carriers of infectious diseases, valleys and heights that put a strain upon the heart, noxious agents, or benevolent moistures, later complicated by the presence or absence of medical care. For the slightest consideration of the question of mental health, we need to take into account not only all that can be known about an individual's state of physical health, which itself can only be evaluated against a known background, but also the circumstances of his social and cultural life, past and present—the state of his emotional, social, and spiritual life.

Someone who sits and weeps saying that he has offended God may be a man profoundly convinced that by some sin he has cut himself off from salvation, or he may be someone with very slight religious feeling who is facing a middle-age depression or trouble with his prostate gland, which has so overwhelmed him that he uses the phraseology of religion. A woman who reports that she is afraid she will kill her husband may be discussing a real temptation, may be acting out a novel she has just read, or may have come recently from a part of the world where the threat of such violence is routine in family life. Although there are a few physical symptoms which, even when considered almost completely out of context, nevertheless imply grave illness or danger of death, the symptoms of the degree of mental health or the amount of mental illness are never so simple. Each individual symptom—extreme fear, black despair, fantastic gaiety, distortion of what others see as the real world, a nagging sense of disaster—may, according to the situation in which it occurs, be either a sign of mental illness or a reasonable adjustment to some detail in the individual's current situation.

However, no matter how relative the interpretation of whether any individual is suffering from mental illness may be, all known human societies at some point decide that some individuals are too mentally disturbed to be coped with by the ordinary means used to reason with the unreasonable, calm the disturbed, comfort the grieving, assuage the feelings of the hot-tempered. When this point is reached, then men take special ways of dealing with their fellows. They may drive them out into the snow only to go after them and bring them back; they may place them in stocks; they may diagnose them as having been entered by a supernatural being who must be exorcised or obeyed; or they may, as in those great societies that deal with human beings by creating special institutions like hospitals, schools, and prisons, build special institutions for the care of the mentally ill.

Our understanding of mental health is impeded today by the exist-

ence in our society of great out-of-date institutions—more like prisons than like either hospitals or schools—where those mentally ill who could not be coped with in their own environment are sent, either in fear or repulsion, by their friends and neighbors for their own protection and care, by physicians, or by officers of the law for the protection of society—usually by all three working in some combination. It is partly because these three functions of a mental hospital are so different, and yet so inextricably combined, that the public understanding of mental illness is so confused. If we consider what it would be like if the same building, under the same name, were used for those who were sick, for those who were illiterate and needed to know how to read, and those who were criminal, we may get some idea of how our care of the mentally ill has impeded our understanding of the problem.

Within the walls of these totally inappropriate institutions, that are still being built to house and permanently deform the lives of thousands, are people who should be thought of primarily as patients who are sick and need rest, better diets, a supporting and protective environment, solicitude and care until they recover. Some of the care they need may be special—such as the use of specific drugs, or even electric shock, or continuous surveillance—but so also is the care given a two-year-old who has had an eye examination, or someone who has been severely burned. The situation of the mental patient is special, and in the new trend toward keeping mental patients of this kind in a local hospital with other sick persons, specialists are naturally concerned as to whether the care will be special enough, and whether the specialists in mental illness, the psychiatrists, will play a significant enough part.

Within mental hospitals we also find individuals who require not so much rest and care as reeducation—people who, as children, learned the wrong way of dealing with life, or in adulthood, under stress, have adopted more and more inappropriate kinds of behavior, trying to deal with people around them by total withdrawal, by temper tantrums and destructiveness, by extreme ritualization of body movements and life routine, by reducing their whole living to some small circle of highly symbolic but nonuseful activity. Here they need teachers, but teachers who, from long experience with the mentally ill, know how to do this kind of reeducation, to teach the untrusting, the fearful, the resentful, that other people do not respond to the methods they have learned to use.

And finally, there are individuals whom we call the criminally insane—whose crimes of violence or fraud are related not to simple

criminal calculations of banditry and personal gain, but to more obscure emotional defects, defects in the control of impulsive behavior, lack of the expected types of sympathy and identification with their fellowmen. Some day psychiatry may know enough about these persons so that they may be identified in childhood and reeducated. At present they commit the spectacular senseless crimes that strike terror into those who hear of them. They should be segregated from the two other types of mentally ill, those who need care and those who need reeducation. In many instances, the criminally insane, like other prisoners or men who seek safety from an uncontrolled life ashore, need only the restraining walls of a special kind of prison to make them into harmless and useful, but limited, citizens, who are unable to live in the outside world because they endanger their fellowmen. This is a small group, just as the callous criminals and the hardened delinquent children, who fall upon and beat up helpless old men, are small groups—casualties of our imperfect knowledge of how to build a society within which every child who is born will have a chance to grow up and realize his best potentials.

But we do not maintain great mental institutions for individuals who need such different kinds of treatment, varying from rest and care (which some homes provide easily and others are totally unable to provide) to reeducation (which can sometimes be gained with the help of teachers and counselors but which at other times is best accomplished during residency in an institution). These institutions are also for those with criminal propensities which may sometimes result in only one disordered act, appropriate in the extreme rural areas but inappropriate in cities, and for those with propensities that are so deep, so unpredictable, and so ineradicable, that custody for life is the only answer. These institutions shape our fears about mental illness; the great load of chronic cases in the understaffed mental hospitals increases our dread, and it is difficult to think clearly about mental health. In fact, in many communities the department of mental health is not what its name indicates—a social counterpart of a department of public health concerned with treatment, custody, and sometimes cure of mental illness.

A better comprehension of the problems of mental health in our national life depends upon urgent attention to our mental institutions and revision of the care of the mentally ill. No attempt to thrust their fate out of our minds and hearts while we concentrate on a better environment for the next generation, or the minor problems of our own

small children, or the worldwide dangers of racial discord or nuclear war, will suffice. Only by facing the full reality of the enormity with which we treat the great bulk of our mentally ill, because of public disinterest, lack of funds, but not—any longer—lack of knowledge, can we hope to arrive also at a concept of optimum mental health.

For, once the varieties of mental illnesses are fully realized and the varieties of care called for are specified and provided, we can begin to think of mental health not as the absence of mental illness, or as approximating some absolute and abstract norm, but as a relationship between an individual's potential strengths and weaknesses and his situation.

We will no longer expect any simple way of equating the mental health of slum children and of suburban children, or the children of old residents and the children of new and unwelcomed immigrants. We will not expect a woman, whose mother died in childbirth when she was five, to approach her own delivery with the fine optimism counseled today, nor the man who three times lost jobs through automation to have as much self-confidence in the face of a hurricane that destroys his new house as the man with a different experience.

Looking at babies born into the same home, mothers will be free to follow their recognition that some infants are more sensitive to touch, to sight, or to sound, and so, with the same exposures, will react much more drastically. We will be able to distinguish between the fears and terrors of the imaginative and unimaginative, and between those of the highly educated and fully experienced, and the ignorant and illiterate, terrorized and disoriented in a society they do not comprehend. We will be able to ask whether the new young mother who buries all the knives because she is afraid she will kill her husband and child is suffering from a serious and dangerous mental illness or from a brief attack of "baby blues" because she has no mother or sister or woman friend to tell her that her postpartum depression will pass.

At present our ability to do this—as a group of laymen—is not very great. So in recognizing that what we are seeking is optimum mental health—the fullest, most adequate response that a given individual can make in the particular circumstances in which he finds himself—it is important also to preserve a protective balance. On the one hand, more allowance needs to be made for sensitive individuals' responses to the vicissitudes of life, to failures at work or school, to disappointments in love, to new situations, to new tasks, and to loss of friends. On the other hand, we also need a sensitive awareness that each individual,

the strongest as well as the weakest, may at some time in his life need help.

As we move away from mixed, inappropriate, out-of-date institutions, which classify many different kinds of mental illness together, toward a more sensitive estimate of each individual's plight and performance, more diagnostic institutions are needed—child guidance centers, family counselors, mental health centers—to which a parent, a spouse, a friend, a teacher, an employer, or an adult on his own behalf can turn and ask: "How am I doing? Given my abilities, my life history, my present situation, is my mental health as good as it can be, or are there steps I could and should take to make it better?" When we seek an optimum—and an optimum is always relative to the particular circumstance—instead of a meaningless maximum, the search for mental health can become significant, a search that results in continuous reasonable gains. These gains will be made, however, in the knowledge that preventive work in mental health has just begun, that the individual whose best is very poor, though optimum for him, would have been able to do better, with better care in childhood, in better organized cities and nations, and in a world where the fear of war is not added to the infirmities and tragedies to which all flesh is heir.

# ABORTION

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## ***What is an abortion?***

This is a term used by a great many authors to refer to the expulsion of the embryo or fetus—through and out of the birth canal while it is still incapable of survival outside the womb—by or before the end of the sixth or seventh month of the pregnancy. However, this is a nonmedical definition.

Medically, the term “abortion” may sometimes refer specifically only to the expulsion of the embryo out of the birth canal during the first three months of its existence. The term “miscarriage” refers to the expulsion of the fetus during the second trimester (three-month period) of the pregnancy. The expulsion of the child during the third trimester is called a “premature delivery.”

In legal terminology, abortion can be defined as the expulsion of the fetus out of the uterus before gestation is complete and therefore before the developing human organism can lead an independent existence of its own. It is this definition that will be used throughout this article.

## ***How are abortions classified?***

Abortions are classified as *spontaneous* or *induced*. A spontaneous abortion is an abortion neither purposefully nor deliberately induced. If a pregnancy is deliberately interrupted—by physical, chemical, or operative means—the abortion is classified as either *therapeutic* or *criminal*, depending upon whether it has been performed legally or in an extralegal environment.

## ***How frequently do abortions occur in the United States?***

Three pregnancies out of every ten are said to end in abortion. There are very few legal abortions. At most, less than 18,000 pregnancies are now interrupted annually for therapeutic reasons. This is a mere drop in the bucket. A million or more are interrupted extra-

*legally. Some authorities, however, feel that the figure may be as low as 250,000; others estimate it to be over a million and a half.*

***Are most induced abortions performed on unmarried girls?***

No. Nine-tenths or more of all artificially induced abortions, whether therapeutic or criminal, are procured or prescribed for married women over thirty years of age who already have three or more children and who have been impregnated by their husbands.

***Can legal and illegal abortions be told apart?***

In most cases, no. Most abortionists for obvious reasons are highly proficient technically. Pregnancies are interrupted legally and illegally by exactly the same procedures.

Unless infection is present, or unless under certain circumstances the aborted fetus can be subjected to pathologic examination, it seems practically impossible to determine whether a given abortion is spontaneous or induced. This makes it almost equally impossible for law-enforcement officials to gather evidence except in those rare but highly publicized cases which the newspapers invariably headline.

***How dangerous are abortions?***

Until antibiotics came into general use, there were in this country more than 2,000 abortion deaths a year. Now, especially if the operation is performed by competent physicians, as it so frequently is, it is practically never fatal. Fatalities do occur, of course, but rarely.

Statistics therefore merely mirror hospital admission policies. Hospitals that have high mortality statistics are hospitals that admit such patients only if they are in desperate condition. Hospitals that have low mortality statistics admit such patients at a much earlier stage.

***What are our prevailing attitudes toward abortion?***

Abortion is considered something to be abhorred.

The necessity for interrupting an occasional pregnancy, in order to save the life of the expectant mother, has been recognized in all parts of the world and in every historic era.

Legally, in a number of countries and in most of our states, it can be justified only if the physical life of the mother is endangered by the continued presence of the pregnancy. In other countries (Austria, Cuba, Denmark, Finland, Japan, Norway, Sweden, Switzerland, the



Soviet Union) and in some of our own states as well, this view no longer holds.

Attitudes toward pregnancy—and toward its interruption—are incorporated in group mores, in religious tenets, and in legal statutes. Over the world, and not in Western culture alone, the approach for the most part has been conservative.

***Do ethical and religious considerations play a significant role in our attitude toward abortion?***

They do. The Catholic Church considers the life of the developing human organism as equal in importance to the life of the mother. To the Catholic, interruption of pregnancy is therefore murder. On the other hand, the ancient Jews deemed it morally wrong, but not criminal, according to the Talmud, to interrupt a pregnancy before the fortieth day, although interrupting it afterward was contrary to the Talmud and therefore criminal.

The attitude of members of the Church of Jesus Christ of Latter-day Saints toward abortion is determined by the fact that the Mormon Church believes life starts only at birth while the Catholic believes that life begins at the very moment of conception. The attitude of the Orthodox Jew toward interruption of pregnancy approximates but is not quite the same as that of the Catholic. However, the deep religious convictions of practicing Catholics and Orthodox Jews do not seem to be a consistent deterrent to interruption of pregnancy. Psychiatrists not infrequently have as patients both apparently good Catholics and Orthodox Jews who previously had been criminally aborted.

Members of the various Protestant sects, and of both Conservative and Reformed Jewry, it should be noted, approach the abortion problem in about the same way the physician does. A formulation like this, however, evades the issue since the attitude of the individual physician is conditioned by his religious beliefs and his feelings about community mores.

This is because, as one obstetrician (Arthur J. Mandy, former Director of the Obstetrical and Gynecological Psychosomatic Clinic, Sinai Hospital, Baltimore, Maryland) has stated, physicians as a whole "think of abortion in one way, speak and write of it in another, and in actual practice conform neither to personally expressed beliefs, nor to established legal or social codes." The implications of this are obvious. They will be discussed in detail later.

***Has any court taken the religious beliefs of the physician into consideration in any abortion cases?***

Yes. If a physician has deep religious convictions against interruption of pregnancy, he will not recommend a therapeutic abortion. This was taken cognizance of by an English court of law that in 1939 (in the Bourne case) went on record as stating that any physician who for religious reasons believes abortions are never justified "ought not to be a doctor practicing in that branch of medicine, for, if a case arose where the life of a woman could be saved by performing the operation and the doctor refused because of some religious opinion, he would be in grave peril of being brought before this court on a charge of manslaughter by negligence."

In a number of our states, the only stated legal basis for interruption of pregnancy is the threat of death to the mother unless she is aborted. This is in contrast to the policy now in effect in England and in various other parts of the world, where in recent years there has been an expansion in the legal as well as the cultural acceptance of social, socio-psychiatric, and socioeconomic reasons for medically induced termination of pregnancy.

This is also in contrast to the unstated and unemphasized liberalization, by interpretation, of the statutes in a number of states.

***Will the law allow abortion in a case of rape or incest?***

Not in most states, unless other factors are present. The incestuous rape in this country of a twelve-year-old child by her father, even though proven legally, was not considered sufficient reason by the court for allowing her pregnancy to be interrupted medically. If a physician had done so, he would have been performing a criminal abortion. On the other hand, in 1939, a British court of law acquitted an obstetrician on trial before it, for having aborted a fourteen-year-old child who had conceived when raped by three soldiers.

***Why is abortion so serious a problem?***

Because most estimates are to the effect that a million or more extralegal, or criminal, abortions are performed each year in this country. Three people are involved in each abortion—the pregnant woman, her sexual partner, and her abortionist. Since the same abortionist may perform more than one abortion, this means that at least two million people—and probably many more—may be involved.

The problem therefore becomes one of prime but dissimulated concern to the community. It involves the emotional health of the pregnant woman, of her husband, and of her whole family unit. It constitutes one of the most contentious of the medicolegal, sociologic, and economic problems that, to quote Norman Cameron, "lie so vexed upon the conscience of our society."

***What does an abortion cost?***

In the United States, fees charged by criminal abortionists are said to range from \$10 to \$6,500. The more usual fee is between \$250 and \$400, depending upon geographic locale, abortionist, and financial status of the patient.

A legal abortion for a semiprivate patient, especially if that patient has Blue Cross and Blue Shield coverage, should cost the patient less. The private patient may pay a great deal more. Two of our patients, who previously had had nonlegal abortions by competent medical personnel, stated that because of consultation and other fees the legal abortions for which they were being evaluated were more costly than their previous illegal interruptions. This reversal of the usual charge is rather rare.

In Japan, an abortion can be obtained for as little as \$5.00. This is less than the price of a year's supply of contraceptives in that country. In the United States, however, preventive measures (in the form of contraception and birth control) are not as costly as an abortion but despite this they have not proven effective enough.

***Why do women have abortions?***

Because they may be physically or emotionally ill.

With the advance of medical science, medical conditions necessitating therapeutic abortion have become insignificant. At least 80 per cent of all therapeutic abortions are therefore performed for psychiatric reasons. Ward patients seldom have their pregnancies interrupted on this basis. Private patients do. This underscores still another aspect of the socioeconomic problems involved. But in any case, even psychiatric indications can be vastly reduced.

Induced abortions therefore are sometimes, but not often, legal. They are usually extralegal. They may be requested because of intrafamily turmoil, a disturbed marital relationship, an unstable social

environment, poor economic status, or a subjectively felt need to maintain the family at its present size.

A large number of other factors may be (and usually are) present.

*Are these socioeconomic factors taken into consideration when ethical and conscientious physicians examine women who request therapeutic interruption of their pregnancies?*

Almost invariably. In almost every phase of medical practice, the emotional and socioeconomic status of the patient is inextricably intertwined with her medical problems and must therefore be taken into consideration when these are being evaluated. This is especially true if therapeutic abortion is under consideration.

The abortion usually is requested, not because severe organic disease is present, but because of the patient's emotional and socioeconomic problems. These reasons are sometimes accepted and sometimes rejected—although they can seldom be stated openly when physicians (obstetricians or psychiatrists) consider whether or not to recommend to the abortion boards of their respective hospitals a therapeutic interruption of pregnancy. Since they are usually rejected, and since in any case the law takes no cognizance of them, a cynical, frequently heard, nonmedical aphorism has come into existence—"the difference between having an abortion or a child," so it goes, "is the difference between having two or three hundred dollars and knowing the right person, or of being without funds and without the right contacts."

This is discussed in detail in the book, *Abortion in the United States*, edited by Mary Steichen Calderone, the Medical Director of the Planned Parenthood Federation of America.

*Who performs these abortions?*

As detailed in the book, *Therapeutic Abortion: Medical, Psychiatric, Legal, Anthropological and Religious Considerations*, edited by Harold Rosen, a high percentage of abortions—nobody would attempt to hazard a guess about the actual number—are performed by competent physicians, and a large number of referrals, sometimes direct and sometimes indirect, come from honest, conscientious, and otherwise ethical physicians in general practice or in the various specialties, including psychiatry and obstetrics, who, according to Sophia J. Kleegman, Clinical Professor of Obstetrics and Gynecology, New York Uni-

versity College of Medicine, "feel impelled to aid those patients for whom they feel an abortion is indicated, but for whom this can be obtained only through an abortionist."

The Alfred C. Kinsey group were impressed by the technical ability of the professional abortion specialists whom they interviewed, by their obvious concern over the plight of women with unwanted pregnancies, and by the low incidence of ill effects from their operations.

Pregnancies are, of course, interrupted by untrained individuals under deplorable conditions of the type so frequently publicized. These are not too frequent, if one thinks in terms of the million or so abortions performed each year. The Calderone book specifically comments about one physician-abortionist, in practice in a single state, who over a period of thirty-five years had approximately 5,000 cases referred to him by 353 physicians, without a death.

One can therefore readily understand why one state's attorney of Illinois publicly stated in 1955 that he is "convinced the large percentage of the medical profession in Chicago is winking at the violation of state abortion laws."

The laws against induced nontherapeutic abortion in all fifty of our states are only sporadically enforced. Even law enforcement officers feel ambivalent about them. Few of us—whether or not we are physicians, jurists, lawyers, ecclesiastics, or sociologists—would wish to be too candid about the abortion practices of our society.

The law does not necessarily mirror popular opinion although it is amenable to popular pressure. This becomes doubly apparent in view of the widespread public demand for abortion facilities, which has made criminal prosecution of the abortionist relatively rare.

Most physicians neither condone nor perform criminal abortions. The stated policy of the American Medical Association is unequivocally against criminal abortion.

***How many criminal prosecutions are initiated yearly against abortionists?***

There are 2,500 or more abortions each day in this country. Theoretically, between half a million and a million prosecutions are possible per year. Less than 500 are initiated.

During the eight-year period between 1946 and 1953, the district attorney of New York County made a concerted effort to obtain convictions. He was nevertheless able to prosecute only 136 cases all told.

***Why are abortionists so rarely arrested?***

Because abortion performed by competent physicians rarely endangers life. The procedure is performed on so many women that meaningful investigation and prosecution become impossible. Even more important, criminal prosecution of the abortionist has little or no public support.

***Why are convictions almost impossible to obtain?***

This constitutes what the law labels an unpopular cause. Convictions are even more difficult to obtain than were convictions against bootleggers during prohibition days. Except for flagrant instances of out-and-out law violation resulting in violence and death, no matter how strong the proof against them, bootleggers were seldom convicted and sentenced by juries of their peers. The same statement can be made about abortionists today. As with the carrying of a flask during prohibition days, a large segment of the population has had personal experience with the abortion problem, either directly or through some collateral branch of the family.

To quote a first assistant state's attorney of Chicago, "A large segment of the population condones abortion. They consider it either all right or, at worst, a necessity." As a result, law enforcement agencies find it "extremely difficult to obtain convictions or substantial sentences for abortionists." Law enforcement is practically impossible.

***Why does this legal impasse exist?***

Therapeutic abortions are restricted by law. Illegal interruptions of pregnancy continue unchecked. If legal, they are performed ostensibly for medical, including psychiatric, reasons; if illegal, the reasons alleged may, perhaps, also be medical or psychiatric. Whether legal or illegal, nevertheless, the reasons (but not the rationalizations) advanced may be and usually are socioeconomic. These reasons have been written into the statutes of the various Scandinavian countries, but in the United States, while they frequently influence the attitude of examining physicians and hospital boards, they constitute extralegal rather than legal considerations. Despite this it is these socioeconomic reasons that are most frequently involved.

The socioeconomic reasons far outweigh all medical (and psychiatric) factors combined, yet, only medical (and psychiatric) conditions—rigidly defined, although far from rigidly stated—determine, for the physician,

whether or not sufficient legal justification can be found for recommending that a specific pregnancy be therapeutically terminated. This requires detailed discussion.

Physicians must obey the statutes of the states in which they practice. These statutes for the most part allow therapeutic abortion only if the pregnancy is a real or potential danger to the physical life of the expectant mother.

This is the only interpretation of their state statutes that most state's attorneys will make if specifically asked about it, and this almost invariably is the only interpretation to be found in most texts and articles on the subject.

*How have our state laws on abortion been interpreted? What, in other words, are the present legal bases for therapeutic interruption of pregnancy?*

The fact that life depends on health, and that the legal distinction between the two is extremely doubtful, was specifically so stated by a British court of law in 1939. During the past ten to fifteen years, in various parts of the United States, statutory indications for therapeutic abortion have been interpreted to include not only (a) the saving of the mother's life, but also (b) the protection and preservation of her health.

This latter exceedingly elastic indication has in at least five states been further interpreted to include (c) the prevention of serious injury, emotional as well as physical, and (d) the attempt to halt the advance of serious medical or emotional disease. For these reasons therapeutic abortions have been performed legally within the past decade, in the delivery rooms of reputable hospitals.

*What is a therapeutic abortion?*

A therapeutic abortion is an interruption of pregnancy to preserve the physical and emotional health of the pregnant woman, or to save her life physically and emotionally. It must be performed by a physician and under prescribed but not too well spelled-out conditions that vary from state to state and, within specific states, from hospital to hospital. The uterus is evacuated, however—and this requires stressing—to correct a pathologic condition that exists as a result of the pregnancy. The developing chorionic tissue is either potentially or actually damaging and dangerous to the pregnant patient. It must be evacuated or excised.

***What, theoretically at least, is the attitude of the physician toward therapeutic abortion?***

This has been most concisely stated by Alan F. Guttmacher (Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City).

It is essentially the basic amoralistic medical attitude so characteristic of the surgeon in his operative removal of other types of pathologic tissue for which, at the present stage of our medical knowledge, surgical intervention is necessary.

***What are the indications for therapeutic abortion?***

Medicine (in the wider use of the term) is subdivided into medicine (in its more restricted connotation), surgery, and psychiatry. Indications are therefore medical, surgical, and psychiatric. Specific medical indications have been shrinking consistently during the past several decades. They are virtually, if not actually, nonexistent. With the development of thoracic surgery, the utilization of hormone therapy, and the widespread use of antibiotic medication, even those organic conditions—essential hypertension, tuberculosis, and heart disease—that previously were thought almost invariably to indicate therapeutic abortion, no longer necessitate the procedure. If a woman, despite severe physical disease, is determined to carry her pregnancy to term, and if all the resources of modern medicine are brought to bear to help her do so, in all probability she will.

Pregnancy, in other words, now seldom aggravates organic disease. According to Nicholson J. Eastman, Professor Emeritus of Obstetrics at The Johns Hopkins Hospital, it is only, in fact, that very small minority of patients with both (a) rheumatic heart disease and (b) a history of previous cardiac failure who need be excepted from this generalization. The majority of women with uncomplicated hypertension can now carry their child to term if they wish to, and with little or no hazard so far as their own physical well-being is concerned. Interruption of pregnancy because of pulmonary tuberculosis has been declining steadily during the past two decades. In the larger medical centers, obstetricians today need rarely see cases of *hyperemesis gravidarum* (the pathological vomiting of pregnancy) so severe and so resistant to current methods of therapy as to require interruption. And even cardiac surgery is now being performed with increasing frequency on patients with severe heart disease who nevertheless desire, and are thereby enabled, to carry their child to term.



But if a pregnant woman with hypertension, tuberculosis, or heart disease does not wish to bear her child, and if the disease process falls within certain categories, then it may be considered sufficient indication to warrant therapeutic interruption of the pregnancy in certain hospitals and by certain physicians and hospital boards. In others, however, it is not, and this sometimes has little or nothing to do with the religious construct within which a specific hospital operates or with the religious convictions of its visiting or full-time resident and senior staffs.

***Do medical indications for therapeutic abortion include so-called eugenic considerations?***

Legally, no. Actually, yes.

Despite the fact that in this country the law concerns itself only with the life and health of the mother, and not with that of the unborn child, a small number of pregnancies are therapeutically interrupted each year for so-called eugenic reasons, not because faulty germ plasm is thought to be present but because it is felt that temporary, deleterious environmental influences may result in the birth of seriously defective offspring. Such interruptions are not actually against the law; they are merely outside it, as are abortions performed on women who have taken thalidomide after becoming pregnant.

Therapeutic radiation to the pelvic organs during undiagnosed early pregnancy (to diminish the size of a fibroid uterus, for instance) is considered by a number of obstetricians as sufficient indication for therapeutic abortion. If the expectant mother contracts German measles before the twelfth week of her pregnancy, this too in some hospitals is considered sufficient indication, since according to some studies 30 per cent of the offspring may develop severe congenital abnormalities. Nevertheless, one-third of all children born to women whose pelvic organs have been so irradiated, and two-thirds of all offspring born to women with German measles, according to the statistics so far compiled, will show no such defect. Some women previously irradiated or with German measles have, in point of fact, sometimes against even militant medical advice determinedly carried their offspring to term.

However, potential fetal pathology in these two cases is, in a great many hospitals and by a great many obstetricians, now considered sufficient indication for the interruption of a pre-viable pregnancy. But

only a very small number of abortions are performed for this reason.

Abortion for eugenic purposes is an extralegal consideration: the law in no state has as yet seen fit to concern itself with the life and health of the developing human organism.

***Does the pregnant woman's socioeconomic status help determine whether a therapeutic abortion will be performed?***

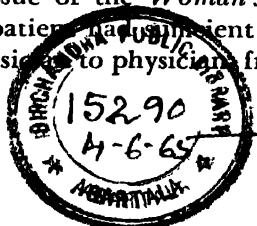
Yes. Some physicians are more prone to recommend interruption, for instance, for a cardiac patient who is unwed, on relief, and already the mother of several children, than for one with the same degree of cardiac pathology who is married, childless, and well-to-do. On the other hand, by the very nature of things, a ward patient is less likely to have the necessary consultations requested, including the psychiatric, and to have the necessary recommendations made and accepted by a hospital abortion board than is her well-to-do sister. Ethical and conscientious physicians decry this fact, but nevertheless find it impossible to controvert it, perhaps even in their own practice.

Socioeconomic conditions never legally indicate therapeutic abortion. Despite this, socioeconomic status frequently determines whether or not an abortion will be performed and whether that abortion will be therapeutic or criminal.

***Are medical indications for therapeutic abortion fairly well standardized?***

No. In contrast to all other medical procedures, acceptable indications for therapeutic abortion vary from physician to physician, from hospital to hospital, and from day to day even within the same hospital and with the same hospital abortion board. This is regrettable, but emotional involvement in the problem on the part of all of us, physicians and nonphysicians alike, is so intense that the abortion board of one hospital may refuse to accept a recommendation for interruption; yet that selfsame application may almost immediately afterward be submitted to the abortion board of an adjacent hospital with, at times, almost the same visiting staff, and be approved.

The resultant confusion is so great that according to an article by Morton Sonthheimer on "Abortion in America Today" that appeared in the October, 1955, issue of the *Woman's Home Companion*, if the abortion-demanding patient has sufficient time before her delivery to shop around from physician to physician, from hospital to hospital, and



from state to state, she in all probability could obtain her interruption legally somewhere in this country.

This is not, however, to be considered the fault of the boards, nor is it something for which the individual physician—general practitioner, obstetrician, or psychiatrist—can be blamed. It is, rather, due to lack of a standard frame of reference: no clear-cut medical or obstetrical indications for therapeutic interruption of pregnancy have been defined or at present exist.

The number of therapeutic abortions for purely medical reasons has been rapidly shrinking during the past two decades. This is because with increased medical knowledge physicians can now treat—and treat successfully—patients with conditions that previously would have threatened with death the expectant mother whose pregnancy continued to term.

We tend to think of abortion as a medical problem, but this concept on our part is purely and simply an artifact of our present social mores. Very few therapeutic abortions are performed—as so many state statutes seem to require—because the pregnant woman would die if the child were carried to term. A large proportion of the pregnancies that are interrupted ostensibly for medical reasons are in point of fact interrupted primarily because of socioeconomic considerations.

The problem for the most part is a sociological and legislative one. Physicians try to meet it on medical grounds. This is impossible. They therefore find themselves at times forced into contradictory, anomalous, or untenable positions. Yet physicians, when they feel it is indicated, would prefer to have the pregnancies of their patients interrupted legally rather than to have them criminally aborted, as so many hundreds of thousands are. Requests for psychiatric consultations are therefore more and more frequent. And recommendations for interruption for psychiatric reasons are now on the increase.

*How can the psychiatrist be helpful when he schedules for consultation a woman who wants an abortion?*

Those abortion-demanding pregnant women who are referred for psychiatric evaluation not infrequently turn out to be emotionally ill patients who happen coincidentally, sometimes even because of their emotional illness, to be pregnant as well. With psychiatric treatment, more and more women who otherwise would request and get abortions, legally or illegally, now carry their pregnancies to term. On the other

hand, there is a physiological time limit with which the psychiatrist is confronted. He may have, at the most, a month during which to treat the patient. This may not be sufficient. However, if a therapeutic abortion is performed for psychiatric reasons, the patient later on may desire, may bear, and may rear—and rear successfully—further offspring.

This is because, fortunately, patients with emotional disease are treatable. Practically all psychiatrists therefore decry the package procedure—interruption of the pregnancy with concurrent sterilization—currently in vogue in so many places. This practice, however, is now on the decline in the more important medical centers.

***When does the psychiatrist recommend a therapeutic abortion?***

Only if in his opinion the emotional life or health of his pregnant patient will be endangered by carrying the developing organism to term.

Most of the problems posed in the psychiatric evaluation of the emotionally sick, pregnant patient are exceedingly complex. The psychiatrist always finds himself faced with the choice of the lesser evil. The problem that he must evaluate is that of whether the emotional health of his patient will be endangered more if the pregnancy is interrupted, or if it is carried to term. He finds it necessary to walk what can best be characterized as a psychologic tightrope.

Most of the time, however, the factors that present themselves are socioeconomic—and therefore legal and sociologic—rather than what most hospital boards, most lawyers, most judges, and most juries would consider psychiatric. It is, of course, exceedingly difficult—and at times even impossible—so to demarcate socioeconomic and emotional factors as to state that one has no psychiatric basis while the other has. The total marital situation, the environment in which the child is to be brought up, the financial status of the family, etc.—all do have profound emotional repercussions.

These are legally recognized in some countries as warranting inclusion among the psychiatric indications for interruption of pregnancy. In the Scandinavian countries, for instance, they have been written into the law. In our country they are considered per se beyond the province of the psychiatrist. He nevertheless must include socioeconomic factors in his evaluation of the pregnant woman's emotional status.

***What about the woman who feels trapped by her pregnancy and states that she will kill herself unless she gets an abortion? Will she?***

Suicide is one of the leading causes of death in this country. There is one successful suicide every half hour. People who threaten to kill themselves frequently do.

However, the suicide rate among pregnant women is less than that statistically to be expected among the population as a whole, even when weighed for age, sex, work group, and social and economic status. Nevertheless, suicide must be borne in mind. It does occur. Eight per cent of all women who committed suicide in Sweden between 1925 and 1944, for instance, were found on autopsy to be pregnant, and in each case on investigation the pregnancy was felt to be the precipitating factor in the suicide. Pregnant women, therefore, do kill themselves.

***Will the psychiatrist recommend therapeutic abortion for a woman who without it may commit suicide?***

Not necessarily. Suicidal patients need psychiatric treatment. Psychiatric hospitalization is usually recommended. If the psychiatrist feels that, as a result of the pregnancy, whatever depressive tendencies are present will be intensified to the point of potential or actual suicide, he will suggest treatment in a psychiatric hospital.

Because of the extreme urgency of the abortion-demanding woman, and because of her husband's identification with her—which prevents him from realizing how emotionally ill she actually is—this recommendation is often rejected by patient, by husband, and by relatives. Commitment is usually impossible. Most such patients refuse to see the psychiatrist even a second time. As an emergency lifesaving measure, the psychiatrist may therefore recommend therapeutic abortion.

***What conditions, in addition to suicidal depression, sometimes justify psychiatric recommendation for therapeutic abortion?***

The psychiatrist may recommend interruption for a number of reasons. Under certain conditions he feels it is indicated for patients whose previous pregnancies had repeatedly precipitated postdelivery psychotic reactions. Some psychiatrists recommend it for specific patients with manic-depressive or schizophrenic psychoses who, for whatever reason, are not amenable to therapy. Others believe it is indicated for lobotomized patients because of the very decided risk that, so it is felt, pregnancy sometimes imposes upon them. If it seems as though a

psychotic reaction will be precipitated as a result of the pregnancy or—and this is to be emphasized—the stress of early motherhood, a number of psychiatrists would make the recommendation for the sake of the expectant mother's emotional and physical well-being. A number are agreed that interruption of pregnancy for psychiatric reasons is indicated in those patients who, because of their very pronounced emotional immaturity, must themselves be babied, cannot be trusted with the responsibilities of an adult, and cannot, in our culture at least, function the way we expect mothers as adult women to function.

But even when severe and obvious emotional disease is present, if a specific woman, no matter how severely ill she happens to be, is determined to carry a specific pregnancy to term, and if every resource of modern psychiatry is brought to bear to help, she in all probability will be able to give birth to that child. If she does not wish to, however, then one of the problems the psychiatrist must attempt to evaluate is the question of why she feels so determined not to have her child. The psychiatrist, like his medical colleague when examining a patient who demands an abortion, not infrequently finds himself at an impasse for the same reason. Most therapeutic abortions are actually for socio-economic reasons.

The psychiatrist can legally recommend termination of pregnancy only if in his opinion psychiatric problems are involved. He can no more recommend it on other grounds, provided he stays within the law, than can his colleagues in general practice or the other medical specialties. Eugenic reasons may be given weight, and so may consideration of the stress of motherhood which, while perhaps an extralegal consideration, does not specifically, at least under certain circumstances, violate the law. Therapeutic abortions have been performed for this reason. But—and this merits stressing and restressing—the patient needs help. Emotional factors in almost every case may be profound.

Because so few organic medical conditions now necessitate therapeutic abortion, the psychiatrist, as a result, whether or not he so wishes, not infrequently must assume the major responsibility for deciding whether a given pregnancy shall be legally terminated or not. This is because, if therapeutic interruption of the pregnancy is not recommended, the patient may instead be criminally aborted.

***Will psychiatrists recommend therapeutic abortion for the sake of the child rather than for that of the mother?***

Some will not; others will. But any decision by a competent, conscientious, and ethical physician to interrupt a given pregnancy can be

reached only after careful and prolonged deliberation. The psychiatrist may give serious consideration to the developing human organism just as, in cases of German measles or of irradiation to the pelvic organs, the obstetrician does. Some psychiatrists therefore may take under advisement the effect on the child of an emotionally very unstable environment.

In an exceedingly thought-provoking article, Richard L. Jenkins (Chief, Research Section, Psychiatry and Neurology Division, Veterans Administration) discusses a group of children whose mothers had unsuccessfully tried to abort them. He comments about those problems of child and adolescent development that constitute so frequent a source of referral to child guidance clinics and that ultimately culminate in the appearance of socialized or "gang" delinquents, and of unsocialized aggressive children, in juvenile courts. Child delinquency and criminal psychopathy require serious consideration by all of us. It should be noted—and this is practically a truism—that the morbid effect of a specific emotionally unhealthy environment on the young child becomes increasingly irreversible as that child grows older. And since schizoid withdrawal—which so frequently is related to maternal rejection even before birth—in childhood is more frequently found in those patients who later develop schizophrenic breakdowns than in those who do not, this in itself becomes one of the most pronounced mental health problems with which the country at present is faced. Schizophrenia in this country fills at least one-quarter of all hospital beds—medical, surgical, and psychiatric—as a result of which, to quote Jenkins, "the question of capacity for maternal response and need for emotional support" must "not be overlooked in considering the important problems relating to the question of therapeutic abortion."

Nevertheless, these and other related questions cannot legally be taken into consideration—no matter how important they are, no matter what being raised in so emotionally unstable an environment may mean to a child—when the psychiatrist makes his recommendations; the established code of ethics of the medical profession and the statutes in force in the various states at present are such as to preclude these and all other comparable socioeconomic factors.

***What, concisely, are the present legal (medical, including psychiatric) indications for therapeutic abortion?***

It is now rarely necessary to perform an abortion in order to save a woman's life. If the statutes of our states are interpreted as written, rather than as they are liberalized by interpretation, then

scarcely any of the therapeutic abortions now being performed are legal. As the Calderone, the Kinsey, and the Rosen books make so evident, the border zone between legal and illegal abortion is narrow, shifts frequently, and is dependent on personnel and geography.

*When known abortions are investigated, are questions of self-incrimination and privileged communication raised?*

Yes. In England, for instance, the maximum legal penalty for the mother who has procured an abortion is life imprisonment. In practice, she is not prosecuted at all. Neither here nor in England need the woman be allowed to incriminate herself. And it is next to impossible to get her to give evidence against her abortionist.

In the United States, since the problem of enforcement of abortion laws is so pronounced, an occasional district attorney, perhaps in desperation, may sometimes take untoward measures in his attempt to obtain convictions. This has been especially true in cities with laws requiring physicians and hospital superintendents to notify their health departments immediately of all abortion cases in which illegal practice is even suspected. The courts have held, however, that such action violates the law of "privileged communication."

*What decision was handed down by the courts when the superintendent of Kings County Hospital in New York City refused to comply with a subpoena requiring him to produce all hospital records of all patients admitted and treated for either miscarriage or nontherapeutic abortion?*

On June 30, 1955, the Second Department of the Appellate Division of the New York Supreme Court decided that the New York City municipal law requiring such notification had to be considered as null and void since it conflicted with the New York State statute prohibiting physicians from disclosing information professionally acquired from their patients. If the subpoena had been complied with, mass information would have been given the district attorney on all abortion cases, whether spontaneous or induced, whether legal or illegal. This, if carried to its logical extreme, would have meant violation of due process of law and abrogation of constitutional safeguards, including that of self-incrimination. This runs counter to the democratic process.

On the other hand, there are a number of states in which the rule of privileged communication does not hold. Yet there has not been a



concerted attempt by a district attorney in any such state either (a) to force patients to incriminate themselves by giving meaningful background histories to physicians and by then having these histories forwarded immediately to the district attorney's office, or (b) to attempt to intimidate physicians into questioning patients and thereby getting them to reveal information that his office, no matter what the rationalizations advanced, could seize upon. If this were done, the physician would no longer be functioning as a physician, but as a detective or an agent of the district attorney. This, it seems hardly necessary to point out, is beyond the sphere of the physician's professional competence, beyond the area of his training, and contrary to his medical ethics.

Occasionally, a physician may be threatened—during a telephone call from a district attorney—with investigation for having recommended in writing that therapeutic interruption of pregnancy be considered for a specific patient whom he has seen in consultation. This is, however, very rare.

***What concrete proposals can be made about the abortion problem?  
Have studies been made leading to recommendations?***

A large number have been made and published. These are discussed in detail, although from different angles of approach, in three books that can be recommended for further study of the problem:

*Abortion in the United States*, edited by M. S. Calderone

*Therapeutic Abortion: Medical, Psychiatric, Legal, Anthropological and Religious Considerations*, edited by Harold Rosen

*Pregnancy, Birth and Abortion*, by P. H. Gebhard, W. B. Pomeroy, G. E. Martin, and C. V. Christenson

***What recommendations have been made by authoritative bodies studying the problem?***

Three such bodies can be mentioned: In 1936 the British Medical Association appointed a committee that published the *Birkett Report on the Medical Aspects of Abortion*. Later, another study, the *Report of the Inter-Departmental Committee on Abortion*, appeared under the joint auspices of the Ministry of Health and the Home Office. This recommended wider dissemination of contraceptive advice by local authorities, clarification of the scope of therapeutic abortion, adequate medical facilities for care of abortion patients, and measures to relieve the financial strain of childbirth.

In 1955 the Planned Parenthood Federation of America called a three-day conference of specialists in obstetrics, psychiatry, public health, biology, sociology, biostatistics, forensic medicine, law, and demography, to discuss the problem. The majority of those participating signed a statement recommending:

- 1) Encouragement, through early, continued, and realistic sex education, of higher standards of sexual conduct and of a greater sense of responsibility toward pregnancy.
- 2) Establishment of consultation centers for women seeking abortion, modeled after the Scandinavian centers now in existence. Such consultative centers would operate under joint medical and sociological auspices, perhaps through the sponsorship of state health and welfare departments. Their main function would be to help women realize that abortion, whether legal or illegal, may not be the best or only solution for the medical, social, or economic problems that seem so overwhelming to them. Discussion and help by informed, trained personnel who would be nonpunitive in attitude would be likely to persuade a woman to follow a far more constructive course than interruption of the pregnancy.
- 3) Extension under medical supervision of facilities for providing advice on contraception, which would be freely available to all desiring it.
- 4) Study of the various abortion laws by authoritative bodies (e.g., the National Conference of Commissioners on Uniform State Laws, the American Law Institute, and the Council of State Governments), which would frame a model law that could, perhaps jointly, be presented to the states to replace existing statutes.

Our present abortion laws cannot be justified rationally except by a process of interpretation that distorts and nullifies them, and that in large measure leads to their practical abandonment in practice.

The vast number of illegal abortions done each year is many times the number consistent with sound medical or social practice, as the conference statement stressed. The goal should be to reduce this number as far as possible. This will require careful candid study by physicians, sociologists, educators, religious leaders, lawyers, legislators, demographers, and other responsible citizens, before an actual solution is reached of all the very urgent problems created by our present treatment of the abortion situation.

# ACCIDENTS

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## ***What is an accident?***

An accident is commonly defined as an event which happens by chance or unexpectedly, especially one which, in Webster's words, is "of an afflictive or unfortunate character."

## ***Are accidents "accidental"?***

In the sense that they take place "unexpectedly"—that is, without conscious foresight or expectation—accidents are usually "accidental." An elderly person suddenly falls while descending the cellar steps. While crossing the street a pedestrian is struck by a speeding car. A child is burned when he knocks a pot of boiling water off the stove.

Such events are usually unexpected, but they are seldom simply the result of "chance"—of the perverse whims of an unpredictable, uncontrollable fate. Chance implies the absence of cause; current research suggests not only that accidents have causes, but that in many instances it is possible to determine the nature of these causes.

## ***Are accidents a serious health problem?***

Citizens of this country suffer a total of about 45,000,000 accidental injuries a year. Of these, over 9,000,000 are disabling, at least temporarily.

Accidents also account for about 93,000 deaths annually. In fact, *accidents are the leading cause of death among all persons aged one to thirty-six, and among males aged one to thirty-seven.* Among persons of all ages, accidents are the fourth leading cause of death, exceeded only by heart disease, cancer, and vascular lesions affecting the central nervous system. Obviously, accidents comprise one of the most serious health problems confronting this and many other countries.

***How do accidental death rates for Americans compare with those of other countries?***

Americans, with an average annual death rate of 52.2 per 100,000, fall somewhat above the world average, due partly to our greater number of motor vehicles. Countries like the Dominican Republic, Spain, Greece, Ireland, and Ceylon have very low rates, ranging from 14.4 to 30.5. On the other hand, Australia, Belgium, Canada, West Germany, Switzerland, France, and Austria, among others, all exceed the United States rates, their figures ranging between 52.6 and 72.7.

***Where do most accidents occur?***

Home accidents account for the largest number of disabling injuries (about 44 per cent), followed in order of frequency by accidents in public places and work situations (each over 20 per cent), and in motor vehicles (about 15 per cent). On the other hand, motor vehicles account for the largest number of accidental deaths (about 42 per cent), followed by home accidents (30 per cent), public accidents (18 per cent), and work accidents (10 per cent).

***Are certain kinds of accidents more frequent at certain ages?***

Definitely. For example, although motor vehicles are the most frequent source of accidental death at all ages up to seventy-five, the situation varies considerably from one age group to another. Thus, death from mechanical suffocation or ingestion of objects occurs more often in children under one year than at any other age. Deaths from fires and burns are most common between ages one and five. Motor vehicle deaths are most frequent among teen-agers and young adults. Fatal falls occur most often after the age of seventy-five. Obviously, these variations reflect the physical condition and stage of mental development of the individual—as well as the types of risk situations to which he is most frequently exposed—at various ages.

***Are there groups of people who have more accidents than others?***

Yes. For example, there are wide variations in accident rates among different occupational groups. Communications and electrical equipment workers have very low rates. In contrast, construction and mine workers have relatively high rates. Obviously, such differences are related in considerable measure to the degree of hazard

inherent in the work situation itself. However, even within a particular group, all of whose members may be living and working under comparable conditions, there may be wide individual differences in accident frequency and severity. Thus, among bus operators driving the same route, some drivers may have five times as many accidents as the average in a given time period.

*Is a person who has many accidents, "accident-prone"?*

This is a frequent assumption, even among mental health workers, but it is not necessarily true. As any gambler knows, it is possible to roll a "seven" many times in a row. In fact, we would expect such lucky streaks to happen occasionally, just by chance. However, an unusually high percentage of "sevens" may also occur because the dice are loaded, and when such a rare event happens, we would do well to investigate this possibility.

In the same way, some people in a given group may have no accidents, some a moderate number, and some a high number—just by chance. A high incidence of accidents does not in itself establish that the person is "accident-prone" (a term implying that his accident pattern is the result of certain enduring personal characteristics, such as persisting psychological traits, or physiological defects). It is possible that this is the case, but the only reliable way to find out is to compare people who have high accident rates with other people who have low rates under the same circumstances. If the high-accident and low-accident subjects are found to differ in significant ways in their personal characteristics, we then have presumptive evidence of accident-proneness. In a number of studies, such differences have been found.

*Are people with high accident rates likely to be poorly coordinated, or deficient in physical skills, such as depth perception or reaction time?*

This is a difficult question to answer because of the absence of comprehensive scientific data in a number of areas. It seems probable that some of the accidents of young children and of elderly people are related to psychomotor (pertaining to muscular action ensuing directly from a mental process) deficiencies. The same thing may be true of other persons with severe sensory or motor difficulties.

However, recent research in automobile accidents suggests that the

importance of purely physical or psychophysical factors in accident susceptibility may have been exaggerated. In one study of relatively healthy young adult males, it was found that "the traditional sorts of measures often assumed to make the biggest difference between safe and unsafe drivers—obvious things like reaction time, depth perception, and eye-hand coordination, as well as psychophysiological functioning and intelligence—seemed to make little difference in most cases."

As a matter of fact, these investigators found on a test of driving skill that the high-accident subjects actually reacted more quickly than the safe drivers, and finished the entire test sooner, but that they made more errors along the way. The implication here is that being able to get one's foot to the brake a fraction of a second sooner than the next person may be less important than driving carefully enough so that such activity is unnecessary.

***Does the intake of alcohol and drugs cause accidents?***

Nearly half of the fatal motor vehicle accidents in Connecticut in 1959 involved a drinking driver or pedestrian. Among drivers, two out of five had been drinking, while among adult pedestrians, the proportion was even higher. Evidence obtained since the widespread adoption of the so-called tranquilizer drugs, suggests that they may be playing a more significant role in motor vehicle accidents than had previously been assumed. It also appears that alcohol and drugs may play a role in other types of accidents, such as those involving falls, drownings, poisonings, and machinery.

***Are psychological factors important in the causing of accidents?***

Research evidence indicates that psychological factors are indeed important—at least in some kinds of accidents.

A Canadian psychiatrist, William Tillman, has argued that "a person drives as he lives." A number of recent findings seem to support this idea. In one study of adult male drivers, the accident-repeater group was found to contain unusually high percentages of persons who: (1) were having difficulty in controlling angry, hostile feelings and who, as a result, were likely to display antisocial, "acting-out" behavior, either at the level of outright physical belligerence, or at the level of verbal aggression—in the form of sarcasm, carping complaints, or destructive comments; (2) were rather unconventional in attitudes and behavior, including a lack of concern with religious

values; (3) either were overly preoccupied with their own fantasy life or, conversely, tended to act on impulse, with little or no capacity for reflection and planning; (4) either were very self-centered or, conversely, appeared overly sensitive to, and worried about, the feelings and opinions of others; (5) showed an incapacity to tolerate tension generally.

Other investigators report encountering such characteristics as emotional instability, impulsiveness, lack of alertness, egocentricity, irritability, foolhardiness, inadequacy, and poor social and vocational adjustment more frequently among high-accident drivers than among accident-free drivers.

In one study of the social adjustment of drivers, accident-repeater and accident-free drivers (matched for driving experience and geographic region), were checked for a record of contacts with various social agencies, such as juvenile and adult courts (nonmotor vehicle charges), credit and collection agencies, and social service agencies. The results showed that 66 per cent of the repeaters were known to one or more of these agencies, as against only 9 per cent of the accident-free drivers.

In brief, there seems to be a consensus among most investigators that psychological factors play a role in susceptibility to motor vehicle accidents. In addition, there is reasonable agreement as to the nature of many of these factors. However, more research is needed before we can be sure how applicable these findings are to other types of accidents, such as childhood or industrial accidents.

### *What about childhood accidents?*

Children's accidents probably differ in a number of important ways from the accidents of grown-ups. Adults, because of their greater knowledge and experience and their more advanced mental and physical development, are potentially better able to notice, evaluate, and respond appropriately to risk situations than the young child.

The adult is basically more capable of anticipating and avoiding accidents, but whether he does so or not may be more dependent on special psychological factors. The child's accident rate, on the other hand, may be more a function of the safety practices and teachings of his parents, and of the number of potential accident situations he encounters. The parent who exposes his child to the normal dangers of living, but who also guides him on how to cope with them, may be contributing more to his child's ultimate safety than either the

parent who allows his child to run loose without proper guidance, or the parent who unrealistically attempts to protect his child from all possible danger situations.

However, it is also possible that some children are psychologically more susceptible to accidents, regardless of the state of their knowledge of, or experience with, potential accident situations. Preliminary evidence suggests that children with high accident rates are frequently stronger and more active than their peers, more impulsive and daredevil in their attitudes, more unstable emotionally, and less well adjusted to their social group.

Much more remains to be learned about the role of psychological factors in childhood and other nonmotor vehicle accidents. Unfortunately, research in these areas is more difficult than in vehicular accidents.

#### *Why is such research more difficult?*

Such research is difficult primarily because of the problem of controlling for the effects of what scientists call "exposure." It is obvious that one is not going to have an automobile accident while sitting home watching television. At least to some extent then, one's likelihood of having an accident is a function of exposure to potential accident situations. The long-haul transport driver who drives 100,000 miles a year without an accident is performing a much more remarkable feat than one who drives 10,000 miles in the same period.

In motor vehicle research, exposure is reasonably easy to control. We can equate accident and nonaccident drivers for such things as miles driven per year and the conditions under which this driving took place. It is much more difficult to control for exposure in studies of home accidents or farm accidents. For this reason, many accident studies in the past have led to false or misleading conclusions.

#### *Do males—or females—have more accidents?*

Sixty-nine per cent of all accidental deaths are among males. Females equal the male rate in fatal falls, but in all other types of fatality males exceed females to a significant extent.

Probably much the same sex ratio holds for nonfatal accidents. How much these sex differences are a function of the greater exposure of males to risk situations (e.g., driving more miles per year), as opposed to the generally "safer" behavior of females in such situations (e.g.,



driving more carefully), is open to question, though both factors appear to be involved.

***Are most accidents caused by chronic accident-repeaters?***

Definitely not. Although a minority of the population (the so-called severe accident-repeater group) has more than its share of accidents, the fact remains that it is the average person, with only a modest previous accident record, who accounts for the overwhelming majority of accidents—on the road, at work, and in the home.

It might well be argued that occasional accidents are inevitable, and are to be expected in the normal course of daily living. Certainly it is true that accidents cannot be eliminated entirely. Simply participating actively in today's complex, dynamic, swift-moving world involves some risk.

Nevertheless, clinical evidence suggests that psychological and physiological factors may play a role even in the average person's occasional accidents. Apparently an individual's susceptibility to accidents is not the same at all times—even when the risks in the external world are the same.

***When is the average person most likely to have accidents?***

We must remember that avoiding accidents involves a number of complex psychological processes: an attitude of constant alertness to the external world; an ability to evaluate possible risk situations, together with the capacity to act quickly and intelligently to avoid them; and the *wish* to do so. Anything that interferes with any of these processes, even temporarily, will increase the individual's accident susceptibility. Thus, such physiological influences as fatigue, illness, alcohol, and sedative drugs (including tranquilizers) may impair a person's efficiency and consequently increase his likelihood of having an accident.

Emotional influences may have a similar effect. Whenever a person is tense and angry, unusually elated about something, or preoccupied with worries, his alertness to potential risk situations and his capacity to deal effectively with them is impaired. Furthermore, he may even fail to care about danger, or in some instances may actually seek it.

***What can be done to reduce the number of accidents?***

This, of course, is the crucial question. Accidents are not a simple matter. Ross McFarland, in his attempt to apply epidemiological

concepts to the accident problem, states that accidental injuries and death "can be interpreted as resulting from the total forces involved in the competition between man and his environment."

Any sensible approach to the accident problem must take account of both these elements. On the side of environment, accident potential can be reduced by designing: safer machines for industry; less hazardous living quarters for older people; better highways with improved access patterns; safer cars, with such things as seat belts and safety door latches; childproof drug and poison bottles with hard-to-open tops; and so on. The possibilities are virtually limitless. Much has already been done in this area. Much more is required.

On the side of man himself, we have even more unfinished business. To the extent that accident avoidance involves a knowledge of risk potential and of proper safety procedures, more safety education is needed both for children and adults. To the extent that physiological competence is involved, every effort should be made to keep the individual healthy and to advise him of his increased accident susceptibility when he is not healthy, whether as a result of temporary fatigue, alcohol, drugs, illness, or physical disability. In cases of obvious danger, some activities, such as driving, may have to be restricted by law.

To the extent that emotional factors—whether temporary or chronic—are involved in accident avoidance, we need to provide a healthy emotional climate for growing children, and psychologically tolerable working and living conditions for adults. We need also to warn people of the increased accident risk they face when their emotional equilibrium is temporarily or chronically disturbed, whether by anxiety, anger, depression, or even by joy and excitement. In extreme cases of chronic disturbance, the individual's only hope of staying alive may be through some sort of psychotherapeutic intervention, group or individual.

Finally, to the extent that we still lack knowledge of the many complex factors involved in accident causation, we should encourage and support further research, both basic and applied.

# ADOLESCENCE

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## ***What is adolescence?***

The term "adolescence" is derived from a Latin verb meaning "to grow up." It is defined in the dictionary as the period of life from puberty to maturity. For the biologist, adolescence is a period of rapid growth. It begins with an accelerated phase that continues until the attainment of sexual maturity, merges into a decelerating phase and terminates when skeletal growth has ended. But adolescence is also a social phenomenon. Its duration is determined not only by biological factors but by the way the particular society defines childhood and adulthood. Thus, the sociologist may describe adolescence as a period when society has ceased to regard the young individual as a child but has not yet accorded him full adult status.

Two conflicting themes can be detected in these definitions. In one view, adolescence is a period of positive attainment, of growth, and of maturation; in the other, it is a period between, a stage of transition. This prepares us for the issues with which we shall have to deal in trying to understand adolescence. The adolescent is striving toward a goal which he is in the process of achieving. Having left childhood but not yet having achieved adulthood, he is confused (as we are often confused) as to who he is.

## ***What are the physical and emotional changes that accompany adolescence?***

Adolescence is triggered by changes in the activity of the pituitary gland, which lies at the base of the brain. The pituitary secretes hormones that influence body growth directly by acting on cells and tissues, and indirectly by stimulating other endocrine glands—the thyroid, the adrenals, and the gonads. The growth hormone of the pituitary causes retention of dietary protein and accelerates the growth of bone. By influencing the thyroid, the pituitary also promotes bone, tooth, and central nervous system growth. By its action on the adrenals, it influences the carbohydrate metabolism of the body. It stimulates

the secretion of adrenal androgens, which are produced in both sexes (although they are commonly termed "male sex hormones"). The androgens cause the growth of sexual hair (under the arms, on the face, and around the genitals) and also influence general body growth. Specifically masculine or feminine characteristics are determined by pituitary activation of the testes in the male or the ovaries in the female.

The emotional changes that accompany adolescence are in part a result of these biological forces, and in part a result of cultural expectations which govern the behavior of each member of society. The particular form of the psychological characteristics will be determined by the rate of biological change, the kind of society the youngster lives in, and finally by the individual features of his own family. The adolescent experiences an increase in body energy and in body tension. This is often reflected in what has been termed "sensation hunger"—a craving for excitement and stimulation. Aware of the approach of adulthood, he begins to strive for independence; at the same time he has not yet ceased being a child and has dependent needs that must be satisfied by his family. The struggle between independence and dependence explains much of the turbulence observed in the adolescent. He is trying to discover who he is. In his uncertainty, he seeks out his age mates, trying to draw from them the strength to be independent of his family. He now faces more clearly than before the necessity of seeing himself as an adult and of assuming the sexual characteristics of his role. He looks ahead to what he will be; there is an increase in his need to be creative. He wishes to exceed the capacity of his elders. His intellectual level reaches a new stage in which he becomes capable of abstract thinking in its highest form.

*Is there an average age at which these changes begin?*

There is, of course, an average age; however, this is merely a mathematical computation based on observations of many individual cases. But more striking than the average is the variation. The earliest changes may be seen between the ages of nine and eleven, but may not occur in completely normal individuals, particularly males, until as late as sixteen or seventeen. Most youngsters will exhibit definite signs of adolescence by twelve or thirteen. On the average, adolescence is complete by eighteen or twenty, but in rare individuals may continue until twenty-five.

***Do adolescents ever wish for these changes not to occur at all?***

A significant number of adolescents, psychologically unprepared for growing up, are reluctant to see the changes of puberty occur. This may be manifest in shame or disgust when the early signs are noticed. Or it may be manifest in continuing to behave as a much younger child even after physical adolescence is well under way. An example of a specific body reaction determined by psychological distress at the beginning of adolescence is seen in the girl who begins to stoop over and round her shoulders so as to diminish the apparent size of her breasts. She may choose her clothes in such a way as to make her look younger than she is and to hide her developing body.

***Why does the adolescent fear these changes?***

Reasons for such behavior are complex and vary from case to case. However, one can expect the reasons to lie in two general areas: an unwillingness to give up the indulgences of childhood and to face the responsibilities of coming adulthood, and a fear and shame over assuming an adult sexual role. The former situation is likely to occur in a child who has been excessively gratified and maintained in a dependent position by his parents. He may see in the coming adolescence the need to give up his privileged position to undertake tasks which he fears he cannot accomplish. The latter reflects confusion about sexuality and lack of preparation for its proper role in life. Sex is seen by him as something dirty and improper. The youngster is upset by the changes in his own body which imply that he is subject to urges he has been taught to regard as shameful.

***Can wishing for such delay ever actually produce it?***

No definite answer to this question is possible. There is evidence that the pituitary gland, which is the master endocrine gland in engineering the changes of adolescence, is itself subject to physiological control by the brain. Thus, pituitary function at adolescence might be disordered because of emotional disturbances. Some clinicians think that unreadiness for growing up could delay the physical process. However, there is no conclusive evidence for this point of view. Menstrual irregularities are frequent during the first few years after menarche. It is also known that emotional disturbance can be associated with failure of menstruation. But this seems to be a nonspecific effect of stress rather than specific to the psychological conflict. Some youngsters

exhibit irregularities in growth curves which show a correlation with emotional upsets. The mechanism of this phenomenon has not been discovered and any conclusive statement on present evidence would be unwarranted.

*Out of their own emotional needs, do some parents ever wish for such delay?*

The answer to this question is an unequivocal yes. There are parents who refuse to dress their children appropriately long after adolescent development has occurred because they do not wish to admit that it has happened. Such parents continue to treat their children as though they were much younger.

*What are the reasons why parents might be reluctant to see these changes occur?*

The reasons may be divided into two general categories. On the one hand, there is inability to grant the independence that goes with adolescence and, on the other, there may be fear of the emergence of sexuality in the child. Just as children grow and develop from one stage to another, parents must grow and develop in relation to them. Some parents can meet dependent needs easily but are unable to give up being the central figures in their child's life. They see puberty as the beginning of a change that will lead the child out of the home and into his own life. They fear loneliness and abandonment because they are unable to develop a more mature relationship with their child. They are made anxious by the prospect that he will make his own decisions and they feel unable to cope as equals with him.

For parents whose relationship with their child has a strong sexual charge to it, the emergence of overt sexual characteristics in adolescence may be threatening because it brings these unwelcome and unacceptable parental feelings more clearly to the fore. The emergence of sexuality in the child is frightening to parents who have never worked out a mature solution for their own sexual feelings. They may fear that the youngster will display forbidden impulses and wishes which they harbor themselves. They react by projecting their own inner concerns onto the child. Unjust accusations of sexual misbehavior are very bewildering to the youngster who may develop a paralyzing sense of guilt or react by doing just what his parents fear since he is already being falsely accused.

***Should adolescents be expected to talk of these changes with their parents?***

If a healthy relationship exists between the adolescent and his parents, he will be able to discuss his puzzlement and his curiosity about the new changes in himself. If the ground for this discussion has not been set by honest responses to the questions of earlier childhood, considerable difficulty in raising these issues may be expected, now that they have become acute. Usually, the adolescent is more comfortable in discussing the physical changes in himself with the parent of the same sex, but it depends a good deal on the kind of relationship he has with each parent.

It is not uncommon, even where a good parent-child relationship exists, for the adolescent to become more secretive about himself at this period. He may wish to work out his own solutions to problems before bringing them up for family discussion. The tactful parent respects this prerogative in his child but will attempt to indicate his readiness to discuss any questions once they are formulated. The youngster will often need help to get a discussion started; failure to raise questions does not indicate that there are none. A suitable book on the subject tactfully offered to the youngster may provide an occasion for a discussion after the book has been read. Or a casual mention of the subject without specific reference to the youngster himself may provide the framework for a freer exchange of information.

Willingness on the part of the child to discuss sex is in general to be welcomed. However, parents should be wary of endless discussions, repetitive in nature, that cover the same ground. This may be exhibitionistic rather than a real search for information and reassurance. Sometimes the problem lies not with the child but with his parents, whose own unsatisfied sexual curiosities are gratified by excessive and prolonged discussion. This can lead to unhealthy attitudes in the child. Both unwillingness to discuss adolescent changes and constant discussion of them indicate problems in interpersonal relationship and warrant consultation with the family physician.

***Is the age of sexual maturation influenced by heredity?***

Family patterns of early or late adolescence can be demonstrated. If the mother has had the onset of her menses early, her daughter is likely to mature earlier than the daughter of a mother with a later onset. A similar relationship is likely to exist between the age onset of

adolescence in father and son. These are, of course, statistical associations and there may be wide differences in a given family.

***Does the beginning of adolescence occur at the same age, and in generally the same way, to boys as to girls?***

In general, the onset of the earliest adolescent changes occurs one to two years earlier in girls than in boys. The first change to occur in the girl is an increase in the transverse diameter of the pelvis and slight budding of the nipples of the breasts. A boy of the same age may display no changes at all. The next change noticed in the adolescent girl is budding of breast tissue and growth of pubic hair. This is followed by pigmentation of the nipples and changes in the lining of the vagina. At about twelve or thirteen, menses begin. In the boy, the earliest changes are growth of the testes and penis. At this period there may also be some swelling and pain of the breasts in the normal boy. (This often concerns the youngster and his parents but is a perfectly normal finding. In most instances, with no treatment, it disappears spontaneously. A brief discussion of this matter with the family physician may save the adolescent boy a good deal of anguish.) He then develops pubic, axillary, and facial hair. The next change is apparent in his voice. The production of sperm in the male occurs, on the average, two years later than the average age of onset of menses in the female.

These differences in the manifestations of adolescence in the two sexes are also evident in differing patterns of growth rate, acquisition of muscle mass, and body fat. The adolescent youngster of either sex will, however, exhibit an increased requirement for calories, proteins, and calcium.

***Does the beginning of adolescence vary among national groups?***

It appears to be true that among the peoples of the Mediterranean, adolescence has an earlier onset than for those of the more northern peoples, though solid proof for this belief is lacking.

***Does it vary according to climate?***

Adolescence may have a somewhat earlier onset in hotter climates. It is difficult, however, to disentangle this finding from the racial differences among the people who inhabit the various parts of the world.



***Does it occur at the same age among primitive societies as in the United States?***

The age of onset of adolescence does vary in different groups. The reasons for this phenomenon are not clearly understood; they may be racial, climatic, or even nutritional. According to some authorities, the average age of onset of menstruation has become lower in the United States over the past fifty years. Some people see in this a reflection of the increasing pace of our society, but this suggestion is purely speculative at the present.

It should be emphasized that adolescence is not merely a biologic phenomenon but is a social phenomenon as well. In some societies the cultural pattern requires an abrupt transition from childhood to adulthood; adolescence is relatively brief and marked by severe stress. Adolescence as a social phenomenon in the United States is becoming increasingly prolonged because of the fact that ours is a highly technical society. We require more and more training of our young people for every occupation. Consequently, we prolong adolescence by delaying the time when youngsters can assume full responsibility for their own lives. In this sense, adolescence terminates at an earlier age in a more primitive society. Less training is required for adult functions; the ability of a primitive society to support a long period of education for adulthood is limited by its meager resources.

***How many persons in this age group are there in the United States?***

The answer to this question depends upon a definition of the age limits we apply to adolescence. If we take the range from ten to nineteen years of age, we find within it about eighteen per cent of our population. In absolute terms (as of 1960) this amounts to approximately thirty-two million young people. Another way of looking at the population distribution is in terms of school attendance. Whereas there are about thirty-one million children enrolled in elementary school, there are only ten million in high school.

***Is the proportion of adolescents to the rest of the population in the United States changing?***

There have been decided shifts in the population distribution in the United States over the past fifty years. These shifts reflect two major factors. One is the changing birthrate. During the period of the depression the birthrate fell markedly. During the early and middle

1940's there was a rise in the birthrate. This, together with the growing size of the population, resulted in many more births. The second factor that influences the proportion of adolescents to the rest of the population is the lowering of the death rate. Many more people live to their sixties and seventies. As a result of these changing birth and death rates, there are more people between the ages of ten and nineteen and fewer in the range of twenty to twenty-nine. These facts have significant social implications. Whereas in 1940 there were 1.67 persons in the economically productive ages (eighteen to sixty-four) for each dependent person under eighteen or over sixty-five, by 1950 this ratio had dropped to 1.56, and by 1958 to 1.31. This greater burden of dependency has, however, been compensated by the great increase in individual productivity as a consequence of the scientific and technical revolution of this century.

***Does the period of adolescence differ in the United States from that of other countries because of our universal education laws?***

Clearly, adolescence, as a social phenomenon, is prolonged whenever compulsory school requirements extend the duration of school attendance. In part, these laws reflect a culture that stresses the importance of education for a democratic society. In part, they stem from the necessities of an industrial society that requires more highly trained workers. A third factor related to the duration of compulsory education is the need for labor. Our society has not yet solved the problem of providing adequate work for all of its able-bodied citizens. The adolescent of limited education and experience is at a severe disadvantage in the labor market. Consequently, the rationale for increased training is all the greater. This provides a problem for the adolescent of limited educability. Whereas some years ago such a youngster could have become self-supporting, he must now remain in school or face unemployment if he drops out. There is a need for the reintroduction of such pioneering social ventures as the Civilian Conservation Corps of the 1930's as a means of providing productive work to adolescents who have reached the end of their academic achievement and who require outlets for their creative energies.

Whatever problems this prolongation of adolescence brings in its wake, it cannot be reversed in the face of the technological developments in our society, developments that bring with them great possibilities for a better life for all. What is required is a greater degree

of concern and imagination to find ways and means of placing youngsters who do not possess the skills for advanced technical training.

*Why does it seem that adolescents as a group exert a force in American life today that is greater than that of previous times and seems continually to be growing?*

While it is easy to agree that adolescents do exert a greater force than they did in previous times, it is more difficult to give an accurate reason for this phenomenon. There are relatively few facts and much speculation.

It should first of all be noted that this is a phenomenon not limited to the United States. It is noteworthy that revolutions which overthrew corrupt governments in Korea and Turkey were spurred by student action. In many countries, students traditionally have played an important role in political life. Recently, this has become an important social phenomenon once again in the United States, with the spread of student sit-in movements and the resumption of the political activity that characterized the student life of the 1930's.

We have called attention to the growing number of adolescents. Thus, simply from a numerical point of view, their influence might be expected to be greater. This, however, is an insufficient explanation. Their growing influence may stem in part from the greater affluence of our society. With more of our families having high living standards, parents have had a corresponding interest in affording their youngsters the privileges they themselves did not have.

Ours is a rapidly changing society. Tradition is less of a force in the United States than elsewhere. Consequently, adolescents are less confined in the possibilities available to them and less restricted in thinking of new ways of doing things. Indeed, in a society which is rapidly changing, tradition is not a very satisfactory guideline for future activity. If our young people are to prepare themselves for a changing future, they must learn different ways of getting along and of organizing themselves than were suitable for us. There are, of course, negative aspects to this very phenomenon. The adolescent needs limits; the weakening of the traditional force of the family leaves him somewhat confused. He thus expresses his surging independence and exerts more influence in society in relationship to diminished control exhibited by his elders.

The great buying power of the adolescent is reflected in the numerous magazines and advertisements directed specifically at the adolescent.

However, while this certainly influences commercial ventures, such as fashions, popular music, and entertainment, the commercial emphasis reflects rather than causes the impact of adolescent influence on our society.

***How are adolescents affected by the great degree of seminudity and public candor about sex, which is evident in movies, television, books, and magazines?***

One should discriminate between frankness about sex in order to supply truthful information and overstimulation of sexual curiosity by entertainment media, which are solely concerned with audience size and profits. Accurate information imparted to children by parents and teachers in order to increase understanding of sex as a physical expression of love facilitates the growth of personality. It removes from sex the elements of the forbidden, the indecent, and the vulgar. This stands in sharp contrast to the display of sex in a teasing fashion which promises access to what is glamorous because it is forbidden and stresses its purely physical aspect. Unfortunately, these two questions are often confused. Those who have the reasonable goal of wishing to protect adolescents against pornography, at times confuse this with denying them any information about sex at all. Those, on the other hand, who recognize sex as a healthy part of adult living, may unwittingly find themselves justifying access to materials that are destructive.

The adolescent has surging up within him a series of complex physiological and psychological changes related to his new sexual role. Excessive stimulation of his sexual responses at a time when he is not prepared to integrate them into fully mature behavior can only produce turbulence, confusion, and ill-considered action.

***Are adolescents affected by the fact that less and less in our society a boy will follow his father's vocation or profession?***

This is an important social phenomenon shaping behavior of the adolescent boy. In tradition-bound societies where a youngster grows up to assume the vocation of his father, adolescence is a less turbulent period. He has fewer choices to make. He finds it easier to emulate his father and more profitable to identify with him.

This may make life simpler but it should be emphasized that it does so only at the expense of decreasing initiative and freedom. In a restricted society, a youngster whose talents are different from those of his father and whose interests lead him in a different direction must

forego them. Ours, on the other hand, is a society of opportunity. It becomes possible for each to realize the potentialities inherent in him. Until he finds himself, he may suffer greater anguish, but once he does, he can achieve greater fulfillment. We must find substitutes in a democratic and mobile society for the traditions that supported adolescents in the more autocratic societies in the past. The boy can learn to admire and respect the integrity of his father's lifework, just as his father can derive his satisfactions, not from having a pale imitation of himself, but from seeing his child flower into a new and different man.

***Are adolescents affected by the fact that thirty per cent of mothers with children under eighteen are in the labor force?***

Between 1948 and 1958 there was an eighty per cent increase in the proportion of mothers, with children under eighteen, who were in the labor force. It is clear that this must have an impact upon growing youngsters because of the change in family living patterns it entails. Change, however, does not necessarily imply change for the worse. Although there are conflicting findings in the literature, there is no good evidence that children of working mothers are less well adjusted. More important than whether mother works is the reason why she works. If she works because her husband is dead, the shifts in family structure and in income are likely to be more significant influences on personality formation than the simple fact of her working. If she works because she finds caring for her children uncongenial, then it is this rather than the issue of working or not working that will have its impact on the family. Moreover, when she goes back to work, the ages of the children, the hours she works, and the adequacy of arrangements for the care of the children, all will be important factors in determining the adjustment of her children.

***How are adolescents affected by revelations of vice, graft, perjury, and malfeasance in high office?***

In the search for personal identity during adolescence, ideals and standards taught in the past are subject to critical re-examination. To find the noble standards of democracy and morality violated by people in public office is a disturbing experience for adolescents. Some react with cynicism; they conclude that each person is out for himself, and that the highest goal is self-preservation. Delinquents frequently refer to corruption by those in public office as a rationalization for their own misbehavior. Violation of public trust has a destructive influence on

the faith the adolescent is able to place in the standards of the adult world.

*What are the adolescent's emotional reactions to the heightened intellectual competition of this decade, in connection with the race for world leadership?*

The stimulus of competition, when it is competition for positive accomplishment, can be a constructive force. Many youngsters are spurred to greater effort by the recognition that our country must depend on them, if it is to achieve its destiny. Unfortunately, the competition is often stressed in destructive terms: the race for a better bomb, a more destructive missile, a more lethal system for bacterial warfare. The urges within the adolescent are to create; the realization that much of the world's effort is directed toward stockpiling weapons not only fails to inspire but is likely to lead to a sense of futility. Some youngsters conclude: If world annihilation is in store, why strive for a future that may never arrive? The mature and capable youngster sees in this predicament a challenge. On the one hand, there is the possibility of a better world than has ever been known; on the other, the threat of no world at all. He sees himself as the hope of the future, since the leadership of the generation before him has failed so miserably.

*What are the adolescent's reactions to the current scare statistics given such wide publication, such as those of teen-age drug addicts, teen-age crime, teen-age syphilis?*

Many adolescents resent the publicity given adolescent crime which tends to stress it out of all proportion and to give no credit for the many constructive accomplishments of his peers. The periodic alarms that preempt the front pages rarely lead to effective action. Curfews and other restrictive measures curtail the freedom of all adolescents because of the misbehavior of a few. Consequently, young people resent such publicity for they can foresee its most probable outcome. On the other hand, adolescents are likely to respond in a positive way to requests that they themselves consider possible action to correct teen-age abuses. In some communities, adolescents have been invited to sit on commissions to study such problems and often make worthwhile contributions. The responsible adolescent does not deny that a problem exists; he insists that only the real problems be faced

and dealt with seriously rather than serve as an occasion for selling newspapers or obtaining political office.

*What are the effects on the adolescent of living in our society where, he is told, anything is possible for him?*

The multitudinous possibilities the American future holds out for the adolescent, some real and some illusory, have a complex effect on his personality development. It is invigorating for him to feel that his fate lies in his own hands and that he can become whatever he has the capability and the energy to achieve. Unfortunately, this message applies not only to socially creative accomplishments but to socially destructive ones as well. Thus, there are pulls in opposing directions. One youngster responds by exerting the intellectual effort to become a scientist, the imaginative skills to become an artisan, or the organizing abilities to establish a new enterprise. Another may look for the easy way out and concentrate on superficial values in the hope of making easy money.

Although ours is a society with fewer social restrictions than many, restrictions do exist. Many young people long for goals they cannot achieve because of race or religion. For others, higher education is simply not possible because of economic disadvantage. Many delude themselves with fantasies of becoming movie stars without the necessary talent (and luck), and thus fail to capitalize on the abilities they have. What is possible in the future for each individual must be constructively defined in terms of his own abilities, motivations, and opportunities. It is here that parents, teachers, and counselors can be especially helpful.

*Are adolescents affected by the fact that today man has the means to wipe himself off the face of the earth and may at any moment do so?*

Some adolescents react to world instability by seizing what pleasures they can. Boys face delays in work or education because of the draft. Girls see marriage receding into an uncertain future. The course of their lives seems beyond their own control. This narrows horizons to the present; it suggests that work for future goals is futile. But this is the reaction of some, not all. Other youngsters are able to see in the desperate situation of the world a challenge to greater effort. It is this that accounts for the renaissance of social action among the young. They see a threat to their future which they must help to control.

***Does jealousy sometimes occur between a girl and her mother as bodily changes of adolescence occur?***

Such jealousies do occur but their extent depends upon the adequacy of the relationship between mother and daughter. Where mother and daughter have been rivals for the father's affection, maturation of her daughter may stir anxiety in a mother who sees her daughter as a more threatening rival. Such a mother may misinterpret her daughter's behavior because of her own feelings and thus lead to a conflict which was initially no more than a one-sided feeling. A mature mother will take pride in her daughter's development and see it as a complement to her own femininity rather than as a threat to it.

***Do jealousies occur between father and son as the son grows taller, huskier, and perhaps stronger?***

The father who is not sure of his own manhood and who is not confident that he can control his youngster may become irritable, excessively harsh, and unreasonable as he sees his son's prowess exceeding his own. He may fear that he will be supplanted as the head of the household. His domineering belligerence may succeed in inhibiting his son's assumption of a more adult and masculine role. Or the son may respond with antagonism, become more assertive, and thus heighten the conflict. Usually, the struggle between father and son is out of their awareness. Frank and quiet discussion, by making each more aware of what he has been doing and why, can put matters back in perspective, if family ties are basically healthy. When the clash is superimposed on fundamental family conflicts, psychiatric help may be necessary.

***What changes may occur in the relationship between the adolescent and brothers and sisters?***

Conflicts about dominance and submission are likely to become more acute in the adolescent in relation to his siblings. He will demand more privileges and more recognition than the younger children. He will challenge the dominance of older siblings established in an earlier period. As he becomes more aware of bodily changes and sensual feelings, he may become uncomfortable with siblings of the opposite sex and avoid closeness. Conversely, he may become more curious about physical structure of his siblings and begin some tentative physical ex-



ploration. These explorations are not unusual in adolescence and should not be regarded as original sin. They do require, however, to be discouraged lest they produce acute distress in both participants. This can be done in such a way as to let the youngster know that his parent understands that he has sexual feelings but that he will not be allowed to express them physically.

***What are the reactions of the adolescent to the birth of a new baby in the family?***

The possible reactions are as varied as the differences in families. The experience can be a very constructive one. The adolescent may respond to the birth of a new child by developing parental feelings that will lead to caring for the baby like a young mother or a young father. He may feel acutely jealous and see the baby as a rival for his parents' affections. If his understanding of the role of sex in procreation is poor, the birth of a sibling may be distressing because of his preoccupation with the parental sexual activity that it implies. He may displace his aversion to sex onto the new child whom he then shuns. It should be stressed that the birth of a sibling need not lead to conflict; if it does, it indicates that earlier issues have not been resolved in a healthy fashion.

***What is the effect on the adolescent if the time of his maturing is much different from that of his classmates and his friends?***

This is a common source of distress for the adolescent whose time schedule differs from the average. The extent of his distress is usually conditioned by two factors: how upsetting the delay is to his parents, and how secure a child he has been. The youngster whose adjustment has been precarious will find a difference in maturation rate much more difficult to contend with than will the one who has been well adjusted. For boys, late maturation is more likely to provoke problems than early maturation, unless the precociousness is extreme. He may doubt his own masculinity and wonder whether he is ever going to grow up. He may feel inadequate and avoid the company of his peers. Such youngsters are frequently unwilling to take physical education classes because of the necessity to *show* in front of other boys. He may be unwilling to take part in parties and dating because he expects to be turned down. The distress experienced in such situations can be alleviated by a frank discussion with the family physician as to

the meaning of the delay; usually, the youngster can be reassured that his development, though delayed, will nonetheless be complete.

For the girl, precocity is as often a problem as delay. Her reaction will depend not only on her family's attitude but as well on the standards in her community. In many contemporary communities, great stress is placed on early sexual maturity. The girl who is late may feel out of things. She may respond by attempting to simulate a development that has not actually occurred. This can be a healthy and adaptive response, if it is not carried to excess. Appropriate methods of dress, hair style, cosmetics, and carriage can assist a girl to diminish the differences between herself and her peers.

***Can medicine or other means be used to accelerate late maturation?***

Where late maturation is normal for the individual, usually as part of a family pattern, medical means to accelerate maturation are ill-advised. In such instances, reassurance that the process will occur in due time is the treatment of choice. Medication may interfere with normal development and produce unwanted side effects. When maturation is delayed because of pituitary, thyroid, or other hormonal deficiencies, specific medical means to repair the lack are available and their use is indicated. They require experience and skill on the part of the physician and should be used only by a highly competent practitioner specializing in endocrinology. (See *Hormones and Behavior*)

***How does the adolescent attempt to cope with the undesirable physical factors of maturing, such as sudden weight gain in girls, acne in both sexes, voice change in boys?***

The most frequent response to the presence of undesirable physical characteristics is a tendency to avoid social situations in which the deficits will be evident to others. The boy with a changing voice may become taciturn. The obese girl may not wish to appear on the beach and may try to get out of physical education classes. Acne can be a great source of distress to the adolescent. He becomes self-conscious about his disfigurement; he may have distressing notions as to why his skin has broken out. A common belief, entirely without medical justification, is the idea that masturbation is related to acne. The youngster who has heard this old wives' tale may feel acute shame about his acne because he regards it as a sign to the world of his sinful activity. Alertness to this possibility may assist the parent or physician to relieve the

youngster's distress by discussing with him the known facts about acne and the falsehoods that surround it.

Avoidance of social contact is easily enough understood but is essentially unhealthy. It results in further isolation and increased distress. Where possible, the self-conscious adolescent should be encouraged to participate in social activities. One can let him know that one understands the reasons for his reluctance to participate but at the same time point out the self-defeating nature of retreat. It is not a matter of reassuring him that what he can see in the mirror is not true; this is simply foolish. But he can be helped to start a constructive program for care of the acne or obesity and to realize that qualities other than appearance are important in gaining acceptance from peers.

***Why do some adolescents at this time gain weight excessively?***

The reasons are not fully understood. Weight gain always represents an excess of calories taken in over the calories burnt in exercise and metabolism. Hormonal, neurological, and psychological factors influence appetite and activity. Obesity tends to run in families; both genetic and cultural factors have been held responsible. Eating may become a substitute satisfaction when other needs are frustrated or may, in adolescent girls, represent an angry defiance of mothers' pressures for social success.

The balance between energy intake and energy output is easily upset in the adolescent period with its marked endocrine changes and its psychological turbulence. The youngster who retreats from physical activity for psychological reasons is vulnerable to obesity. Careful metabolic studies of obese adolescents have demonstrated that they are far less active than their normal peers; it is the activity reduction that is the major factor in their obesity. (See *Obesity*)

***Why do some adolescents, girls especially, begin to diet severely at the onset of maturity?***

Social and personal factors are responsible for this fad of dieting. Girls normally become concerned with appearing attractive at this period. They respond to current ideas of what is attractive; fashions in the United States emphasize slimness as a desirable physical characteristic. Hence, many girls will go to great lengths to acquire a figure in keeping with "Hollywood" and "Madison Avenue" standards. This response, though at times carried to excess, is basically a healthy adaptation to prevailing social custom.

***Why are adolescent boys suddenly overattentive to dress, hair style, and physical appearance?***

The adolescent boy is very eager to fit in with his peers. He becomes very concerned with matching the standards of his group and avoiding difference. Being attractive to girls becomes important for the first time. He imitates the prevailing standards of dress and appearance determined in fashion centers and ballyhooed by advertising, television fads, and movie heroes.

***Why do some adolescents have such a strong desire to smoke, drink, keep late hours, etc.?***

The adolescent urge to grow up rapidly is probably no stronger today than it was in the past. However, the less strict standards of our period and the weakening of parental authority permit this urge to demonstrate itself more rapidly and more openly. When these procedures are endorsed by the community, then the ordinary checks and balances are removed and the trend can rapidly get out of hand. While we must applaud and accept as normal the adolescent desire to grow up, we need not accept emulation of the less desirable features of adulthood. The adolescent can be discouraged from practicing these false external symbols of adulthood and be encouraged to assume responsibility and independence in constructive ways.

***What are the adolescent's reactions if he is "the only one" not allowed such adult activities?***

He is very likely to respond by becoming rebellious and antagonistic. He feels that his parents do not understand him and that he is being treated as a child while his friends are being treated as grown-ups. The severity of his reaction will depend on how good his relationship is with his parents. However, one need not permit or approve undesired activities merely because other youngsters indulge in them any more than one would condone any antisocial behavior simply because of its frequency.

***Physically, why does the adolescent often seem lazy, spiritless, and fatigued?***

These frequently observed characteristics are very likely to be physiological responses to the marked body changes that are occurring in the adolescent. If persistent or severe, they should be investigated

medically, but ordinarily they can be expected to correct themselves if good physical hygiene is encouraged.

***Are there any sports or other physical activities which might impair the development of the adolescent?***

Many authorities deplore severe body contact sports in early adolescence. In this age, as in any other, excessive physical exertion without adequate rest can be injurious. It should be noted that there are considerable disagreements among physicians as to what is to be permitted and what is to be forbidden at this period. Questions are best resolved by discussion with the family physician.

***What feelings do parents sometimes have when they see their young adolescent dating?***

Most parents are genuinely pleased to see another important milestone reached. To some, the beginning of dating means the end of childhood much to their regret. Others may be jealous as the youngster moves toward an age and an independence which makes him a rival in their eyes.

The parent who has been neurotically attached to his adolescent child may, surprising as it may seem, react with jealousy toward the date as though the date were a rival for his or her own affection from his child. Parents, when troubled by such feelings, may go to great lengths to interfere with the success of the dating experience in order to keep the child within the bounds of the home. While many parents experience these feelings briefly and mildly, they can become serious hazards to the adolescent if the feelings are pronounced and severe.

***Are there hazards to individual maturing in early steady dating?***

Dating patterns are essentially socially controlled opportunities for young people to get to learn about potential partners of the other sex. Healthy individual development requires a fairly wide exposure to a variety of different partners in order that a wise choice may ultimately be made and comfort developed in dealing with a variety of others. Thus, individual personality development is inhibited when steady dating occurs early and becomes exclusive.

***What sexual hazard exists in such early and exclusive relationships?***

When a boy and a girl date each other steadily from early adolescence, early experimental sexual behavior such as kissing and neck-

ing soon becomes tame; the biological feelings in each urge them on to more extensive sexual exploration. Under these circumstances, they may be led into premature activities for which they are not ready and which may be damaging to them.

*What are the psychological rewards for the young adolescents who "go steady"?*

Steady dating enables the youngster to avoid the uncertainty and the anxiety involved in asking others for dates. One need not fear being rejected. One has the comfort of being with someone one knows and can count on. These "rewards" are acquired at a heavy cost because learning how to get along with others is severely inhibited.

*What need is the adolescent demonstrating when such dating becomes exclusive and seemingly permanent?*

The youngster who relies exclusively on the steady date is indicating his social fearfulness and his lack of confidence in his ability to attract and hold other friends. Often, his steady dating may be a rebellion against his parents' insistence that he avoid a particular girl who is not pleasing to them.

*What are the signs of situations which may be truly dangerous to life, or to moral standards, among the adolescent in his group?*

Group adolescent activities that are carried on without any adult supervision, that require excessively late hours, and that take place in undesirable sections of the community should be actively discouraged. Such "sports" as drag racing, drinking parties, restless searching for cheap "thrills" carry a heavy risk.

*Are parents justified in forbidding participation by their son or daughter when the group practice in dating is at variance with the parents' code?*

The answer to this question is an unequivocal yes. Parents should be sure, however, that their own standards are reasonable and not merely the reflection of lack of trust or morbid preoccupation with supposed dangers that do not exist. Parents have a right and a responsibility to guide their adolescent child in healthy dating activity. They should no more approve of practices which seem to them to be improper than they should condone other antisocial behavior.

***Does it increase the adolescent's will and wish to do something when it has been forbidden by his parents?***

Since adolescence is a period of striving for independence, it is to be expected that those things which have been forbidden by adults tend to look all the more glamorous. The extent of the counterreaction will depend upon the basic health of the relationship between the adolescent and his parents. If the adolescent is certain of their interest in him, and that they are making an effort to understand his needs, he will be able to avoid the things forbidden by his parents, even though he may find himself attracted to them.

***Why does the adolescent appear often to choose his friends from among religious, social, and racial backgrounds that differ from his?***

This can be best understood as the adolescent's effort to broaden his experiences with new people and to test out the limits that have been set by his parents. With some adolescents this takes an extreme form as an expression of rebellion against what may have been excessively strict control in earlier years. If his effort to choose friends of his own is met by stern opposition on the part of his parents, it is likely to increase rather than to diminish this tendency. Parents who are concerned by these trends can take comfort from the statistical fact that most adolescents do make their final and permanent choices most often among youngsters with similar social and family background.

***Why do some adolescents show a tendency to make friends only among the handicapped, the outcast, or the underprivileged?***

While in some adolescents this is an expression of sympathy for those less privileged, in others it represents a choice determined by a sense of inadequacy. The youngster who does not have confidence in his own basic attributes may feel more comfortable among those stigmatized by handicaps. He may feel that they will accept him more readily, since the competition is not as keen.

***What causes the adolescent to proclaim that his father is only a moderate success or even a failure?***

The rising generation always challenges the old. In his new surge of strength, the adolescent often feels that he must wrestle figuratively with his father. By belittling his father, he elevates his own status. This developmental reaction appears in an exaggerated form when

there has been a prior struggle between father and son with marked underlying hostility. Then the challenge to parental authority may take an unhealthy turn. When a child concludes that his father is inadequate, this leads to a sense of inferiority, for he also sees himself as his father's son.

*What are the implications of the parents' wish that their son or daughter "amount to more" than they have?*

The trend to urge children on to greater success than parents have achieved is part of the American ethos. It can encourage maturity in the child by demonstrating that his parents do not feel threatened by his emergence and will assist him to success. This assumes that the parents are setting realistic standards and are not belittling their own achievement. If they expect the child who lacks the necessary endowment to go on to college when they themselves have been unable to do so, they are only leading to greater frustration for him and for themselves. If they ask of him that he achieve greater success than their own very considerable success, they may face him with a frightening task, since the standards seems beyond attainment.

*Why do some adolescents who have been good students seem suddenly to stop working and stop trying—even to stop caring?*

This can be taken as a sign of emotional turbulence within the child. The particular problems he will be working out will vary from youngster to youngster and no general formula can be given. Growth, both intellectual and physical, during this period of life tends to occur in spurts followed by plateaus. What seems to be a cessation of work and effort may represent a developmental plateau that will be succeeded by another spurt of effort. When it persists for a long period of time, however, it is an ominous development. It should be discussed with the school counselor in order to determine the reasons and to take action to correct the situation.

*Why does an adolescent become a truant?*

Truancy is found most often among youngsters who have had a long previous history of inadequate and marginal adjustment in school. It is also more often found in children of families whose educational attainment is limited. When the adolescent truants, he is running away from a challenge. The danger lies not only in the schoolwork



missed but the opportunities for antisocial behavior available to the adolescent who wanders about the city streets. By definition in most states it constitutes delinquent behavior. Whatever the definition and the legal action, it is clear that parents have a heavy responsibility to explore the reasons for this behavior and to correct it.

*✓What are the emotional factors involved in the choice of a life's work?*

These are far from fully understood. One important element is the emulation of parents or other admired persons. Another is the image of success ascribed to the occupation by the ambient culture. At other times the "choice" is based upon avoidance rather than desire. This is provoked when a family has insisted rigidly that the child follow a particular career; he then chooses anything but that career. If he is unable to rebel directly, he may appear to acquiesce in the family choice but acquire such a poor academic record that the career is no longer possible. Even when his family does not apply excessive pressure, he may behave as though he feared that they would and turn to someone outside the family for advice. Well-trained guidance counselors in secondary schools can make a major contribution to proper career choice; unfortunately, they are in short supply.

*Why does the adolescent appear to need so desperately to become independent of his home?*

No matter how good the home, normal development in adolescence requires the acquisition of independence from it. If the adolescent is to grow into a responsible and secure adult, he must experiment with freeing himself from his ties to his parents. At times he may cut those ties when he still needs them or treat his parents as though he no longer wanted to have anything to do with them. But if his parents can be calm and steady, he will return to a relationship which he still needs and which will continue to be important to him throughout his life.

*✓What are the emotional factors involved in the subject of money?*

Money becomes a key symbol of independence in adolescence. The arguments that frequently upset family life over allowance and spending money are condensations of involved symbolic struggles between the adolescent and his parents. He wants to be allowed to decide how to spend his own money; within the limits set by family

income, he is certainly entitled to make this decision for himself if he is ever to learn how to handle money. As a responsible member of the family, he can be expected to contribute to it when family resources are meager. Most parents feel that the experience of earning his own money is an important one for the adolescent. But many of the same parents will then take over the money he earns and deny him the satisfaction of controlling its expenditure. This is likely to lead to frustration and conflict in the family. If he works for his own money, it seems only reasonable to expect him to have some say in how that money is spent. If he is given an allowance, since the function of an allowance is learning how to budget and to make responsible decisions, it should be managed as his judgment dictates. To give "an allowance" and then tell the youngster how to spend it is to subvert its purpose.

***Does the adolescent have any fears of independence?***

A characteristic feature of adolescence is what has been termed the ambivalence of the adolescent toward the issues of dependence and independence. On the one hand, he wishes to be free of the tie to his parents; on the other, he feels his need for them very strongly. By turns, he expresses his revolt against parental standards and then an almost childish need for their reassurance and affection. The independence for which he strives awakens fears in him as to whether he will prove adequate to the task. He will insist upon being permitted to make his own decisions and in the next breath ask his parents for money that he could readily enough earn for himself. The wise parent will give his adolescent child enough rein to make his own mistakes, support him when he is perplexed, and decide for him when he is bewildered.

***What is the nature of strong attachments which sometimes develop between the adolescent and a person of his own sex and age?***

Adolescence is a period of experimentation. The youngster is trying out various roles in life. He is learning about other people and trying to replace his dependent attachment to his parents by relations of parity with his peers. For the first time he is capable of strong and binding friendship. It is characteristic of the intensity of his emotions at this period of life that these friendships become exceptionally strong and demanding. Consequently, they often collapse and shatter when

friends fail to meet excessive expectations. He requires of his friend that he be parent, child, and lover to him. As the adolescent matures, his relations with his peers become less demanding and more enduring.

***What is the nature of such strong attachments with an older person of the same sex as the adolescent?***

These attachments are displaced feelings that are derivatives of parental attachments. In his struggle to become independent, the adolescent fears his dependence on his parents. He is more able to accept the counsel of an older person outside the family, a person who becomes an image of his ideal self grown up. These attachments tend to be highly idealized. They are vulnerable when the idealized person fails to live up to the high expectations of the adolescent. These relationships can be quite useful to the adolescent; they are dangerous only when the adult exploits the relationship for his own ends.

***How strong are the adolescent's sexual drives and what are the emotional factors involved in these drives?***

The release of sex hormones that accompany puberty have as their psychological correlates sexual desire and striving. The adolescent becomes aware of his body in a new and different way; he becomes responsive to sensuous pleasures that previously had no meaning for him. If these physical sensations can be fitted into a basic understanding of sex as a normal life function, their emotional accompaniment will be pleasurable. If information given the adolescent is inadequate or misleading, the changes in himself are puzzling and confusing. He may try to deny his changed state and to avoid any situation in which his feelings are stimulated. If he doubts his own adequacy, he may feel compelled to prove his sexual competence by exhibiting promiscuous sexual behavior.

***Are the adolescent's feelings toward the physical aspects of his parents' marriage likely to undergo a change?***

This will not prove to be a problem for the adolescent who has had an adequate sexual education and who enjoys a good relationship with his parents. For the youngster to whom sex has been depicted as something dirty, thoughts about his parents' physical intimacy may produce feelings of disgust and shame.

***What causes the adolescent to participate in degrees of sexual contact with a member of his own sex?***

Such sexual contact, widespread in adolescence, is largely experimental in nature. He is curious about himself and others and wants to understand and to experience more widely. In the normal adolescent, these contacts are fleeting, brief, and promptly broken off. When they persist, they indicate personality difficulties which require professional help. Even the experimental contacts, however, are likely to evoke feelings of guilt, since the youngster knows that they are forbidden by the code of the community. If his shame is unwisely multiplied by the overharshness of his parents, he may become morbidly preoccupied with the question as to whether he is a sexual deviant. The wise parent will gently discourage such activities and indicate to his child that they are self-defeating and inevitably frustrating, but will support him by indicating that such experiences are not unique nor are they permanent. If the partner in the episode is a convinced homosexual, particularly if he is older, the experience carries a significant psychological hazard for the adolescent. Such associations should be terminated.

***What are the adolescent's feelings about masturbation?***

Masturbation is an almost universal phenomenon at this period of life. The reaction of the adolescent to his behavior is determined by his beliefs. If too much of an issue has been made of this matter, it is likely to lead to preoccupation with masturbation and to bring about the very opposite of what the parents consciously intended. Providing a full and active life with outlets for physical energy through athletics will help to keep matters in proportion. Popular but totally false myths that masturbation leads to mental disease or deterioration of the brain can produce acute anxiety in the adolescent. The mental turbulence is not the result of the masturbation itself but of the concern about it.

***How does the adolescent cope with his sexual drive in relation to members of the opposite sex?***

This drive, which arises long before there are socially sanctioned paths for its expression, leads to derivative activities. Partial expression and satisfaction is achieved by looking and touching. Thus, the adolescent is fascinated by pictures that suggest or depict nudity. He seeks opportunities for necking and petting. He may carry his sexual

explorations further, overtly or covertly, if his community permits this. There is reason to believe that some of the physical energy that would otherwise express itself in sexual behavior may be expressed in sport and exercise. In similar fashion, sexual discussion with his peers permits him to satisfy his curiosities without transgressing the rules of sexual behavior.

***What are the needs of the adolescent girl who becomes sexually promiscuous?***

The needs that underlie promiscuous behavior vary. It may be an enactment of family patterns. In other instances, the promiscuity may not be sexually based at all but may represent a futile effort to obtain acceptance and affection. In still others, the promiscuity may be an effort to rebel against family standards and to simulate what the youngster takes to be adult behavior.

***Why do some adolescent boys wish to seduce and then abandon "good" girls?***

Some boys exhibit this behavior to demonstrate virility because they doubt themselves. When this is a repetitive pattern, it suggests conflicting feelings toward women, probably stemming from an unhealthy maternal bond.

***Why are some adolescents sexually susceptible to considerably older persons of the opposite sex?***

Interest by an older person is flattering to the adolescent. Since he is often fearful about initiating explorations with his peers, he welcomes the overtures of an older person who "knows the ropes" and who, by taking the initiative, removes responsibility. In most such situations, a faulty relationship with his own parents will be found at the basis of his vulnerability to an older sexual partner.

***How does the adolescent accept his own sexual behavior if it is counter to the strictures of his family, community, or church?***

When his sexual behavior differs from community standards, the adolescent most frequently strives to find support for it in a peer group which shares the values implicit in his behavior. He can often derive sufficient reinforcement from his gang to enable him to continue in behavior which is nonetheless conflictual for him. He may

rationalize his behavior by deriding the standards of the community as old-fashioned or bourgeois. Cooperative efforts by parents to provide constructive peer groups for adolescents will help to avoid the dangers inherent in a rebellious gang that may be strong enough to counter-balance influences of family and church.

***What are the emotional aspects of very early marriage?***

The individual mature enough to marry successfully at a very early age is rare in our society. This is reflected in the high divorce rates found among those who marry very young. Many of these marriages are precipitated by premarital sexual experience and the resulting pregnancy or guilt even when pregnancy does not occur. Some adolescents who marry young do so to escape a parental home which has become hateful for them. Others will choose this course in response to social pressure, as is evident when a fad of early marriages runs through a high school. The youngsters who behave this way, though they are influenced by the social climate, are youngsters vulnerable because of the inadequacy of relations in the home. These marriages have a high likelihood of failure; both partners lack the maturity to adjust to the give and take of a normal marital relationship. They are unprepared to meet the dependent needs of children and may respond with jealousy to the affection of the other partner for the newborn baby.

***What emotional factors cause some parents to abet and encourage early marriage?***

A mother who doubts the attractiveness of her daughter may encourage early marriage by her constant nagging that the girl avoid the hazards of spinsterhood. One or another parent may actually be eager to have the youngster out of the house and on his own. A parent may feel threatened by the sexual maturity of the adolescent and fear some evil consequence unless early marriage is accomplished.

***Why do some parents find early marriage intolerable and unacceptable to the point of rejection of the son or daughter?***

Parents can have good reason to doubt the wisdom of very early marriage. On the other hand, when a marriage has occurred or seems inevitable, the response of rejecting the offending child indicates that the parents are thinking not of the child but of themselves. They say

in effect that the child must do as they wish or he is no longer their child. Such parents may have brought about the marriage itself by taking a violent and intolerant stand, thereby converting the issue into a struggle for control.

***Is it wise for parents to fight against early marriage?***

If by fighting is meant scenes and threats, the effect is likely to be the contrary of what the parents intend. They may push the youngster to stick to a decision about which he may have had doubts. He forgets those doubts once he is involved in a fight to establish his independence. The wise parent will indicate to his child his reasons for questioning the decision and will work for delay rather than take a stand of adamant opposition. Delay in action may provide the time for both youngsters to recognize the unwisdom of an early marriage.

***✓ Why do some adolescents retreat into sports, intensive body building, and spartan regimes almost to the exclusion of all other interests?***

This pattern of behavior is responsive to two needs of the adolescent boy. It is an attempt to develop his physique in order to increase his apparent masculinity and thus his acceptance by others as a man. At the same time, it provides an outlet for upsurging physical energies which might otherwise demand sexual expression. It is influenced by social factors and will be far more frequent in communities where a high prestige value is placed upon success in athletics. Occasionally, it represents an unhealthy asceticism in a futile effort to deny sexuality.

***Is adolescence a period in which giftedness may reveal itself though not previously obvious?***

While general intelligence is likely to have been evident early in the elementary school years, special talent may manifest itself for the first time in adolescence. The urge for creativeness and individual expression is strongest at this period. When these urges occur in an individual with unusual gifts, what appear to be new characteristics emerge, although closer inspection might have shown them to be latent at earlier periods of life. The fact that giftedness may manifest itself clearly for the first time in this period is a strong reason for avoiding final decisions based on performance in earlier grades. Rigid adherence to educational plans based upon judgments made before

adolescence deny the youngster who is a "late bloomer" the opportunities to which he is entitled. (See *The Gifted Child; Intelligence*)

***Why do some adolescents become strongly (almost fanatically) idealistic and deeply concerned with world betterment?***

In the struggle to find oneself in adolescence, the ideals and values with which one has been brought up are strongly challenged and questioned. The capacity for conceptual thinking reaches its first peak in this period. With the boundless energy of adolescence propelling him, the youngster cannot accept compromises or partial measures. Concerns for a better world are healthy trends in the adolescent, even when their expression is unrealistic. It is upon these early manifestations that prevailing concern with one's fellowman is based.

***Why do some adolescents become especially vindictive and contemptuous of their fellowmen?***

The adolescent who is filled with feelings of hate is vulnerable to this course of development. Studies that have been made of the adolescents who become members of hate groups indicate overwhelming hostile and aggressive feelings rooted in hatred of authoritarian and overpunitive families.

• ***What are the beginning signs of delinquent behavior in the adolescent?***

The delinquent or predelinquent adolescent is frequently a youngster who ignores his schoolwork and is a truant from school. He defies community standards with respect to hours and places. He is involved in frequent fights, often with younger and more defenseless children. He takes little responsibility around the home or in the community. If the progression is not halted, he goes on to more serious antisocial behavior. (See *Juvenile Delinquency*)

***What do gangs mean to the adolescent, and why does he join them?***

Delinquent behavior, violating as it does the norms of the community, requires reinforcement and support from others engaged in the same behavior. The rejection the delinquent feels from the community at large is offset by the acceptance he obtains within the gang. The gang becomes not only a haven but a further factor in reinforcing the delinquent behavior as it sets demands on its members for continued delinquent activities as the price of belonging.



***Why do some adolescents from financially sound families steal?***

The adolescent who steals under these circumstances is usually quite different from the one whose stealing occurs in the midst of poverty and family deterioration. His stealing is an expression of individual rather than social psychopathology. Denied the love and affection he needs, he responds by stealing what he has not been given, sometimes in anger, sometimes in despair. His stealing may be a deliberate effort to expose his family to community censure.

***What are the adolescent's feelings if his parents' marriage is markedly unhappy?***

At the least, this makes it difficult for him to envisage marriage as a successful experience. It may lead him to doubt the sincerity of his parents' affection for him since they seem unable to love each other. The emotional turmoil aroused in the adolescent by parental discord may reflect itself in poor schoolwork, maladjusted behavior around the home, and avoidance of social contacts. Such an adolescent fears that his friends may learn of his family difficulties and will avoid bringing them home.

***What are the emotional effects of divorce on the adolescent?***

Divorce is an upsetting experience for a child at any stage of life, but it can be less hazardous than endless turmoil when parents cannot resolve their difficulties. The adolescent is likely to experience acutely divided loyalties, and will resent parental efforts to win his allegiance. It casts a pall on his plans for the future, since the security of home is no longer available to him. (See *Emotional Problems of Divorce*)

***If the parents have been divorced, might the adolescent's attitude change toward the parent with whom he resides or toward the other?***

As part of the stocktaking that goes on at this period, the adolescent is likely to reassess his feelings toward both parents in the case of an earlier divorce. It is not uncommon for a youngster suddenly to request to live with the other parent, as part of the effort to understand what happened and to define the relationship with the missing parent. He may suddenly, after having apparently accepted the divorce over several years, begin to torment the parent with whom he lives as to the blame for the separation. It should be emphasized that these changing feelings can be managed and need not lead to crisis and conflict.

***How is the adolescent affected by the death of a parent during this period of his life?***

The adolescent has not yet determined just who he is and where he fits in the scheme of things. He very much needs both parents. If one dies during this period, he is bewildered and perplexed. He will need help to work out his feelings toward the deceased parent. If the parent dies at a time when the adolescent is struggling with hostile feelings toward this parent, the sudden death may lead to feelings of guilt and responsibility for the death. Although the adolescent may display little or no feeling, this does not mean he is experiencing none. It is important that he be helped to work through his mourning by being encouraged to express his feelings. Foreshortened or unexpressed mourning may lead to psychopathological symptoms at a later time in life. (See *Death; Grief; Guilt*)

***If he has been adopted, how does the adolescent feel about his real parents?***

As part of his search for himself, he is likely to become preoccupied once again with the identity of his real parents. He may create elaborate fantasies as to who they actually were, fantasies which exaggerate their social standing and provide excuses for their inability to care for him. Adoptive parents should recognize that this is a frequent phenomenon. They should welcome opportunities for the adopted child to talk about his feelings and answer his questions as best they can. They can best support him by indicating that they understand his concerns without doubting his love for them. (See *Adoption*)

***What do intense depressions and talk of suicide mean in the adolescent?***

Adolescence is a period of hyperbole. Talk of suicide is often a histrionic gesture which serves to convey *Weltschmerz*. However, it requires to be listened to seriously and compassionately, and never should be challenged. When such talk is prominent and repetitive, it indicates serious mental disturbance and should lead to medical consultation. (See *Depressions; Suicide*)

***♥ What are the early signs of mental illness in the adolescent?***

The mentally ill adolescent is likely to express his difficulties by withdrawing from contact with others and relying excessively on his own inner thoughts and fantasies. School grades are a sensitive index

of adjustment; sudden change for the worse after a long period of adequate school performance suggests emotional turbulence. Violent outbursts of rage or prolonged periods of despondency are additional warning signs. Overzealous religious preoccupations at this age may be regarded as a sign of emotional disorder.

*Can parents hope for a new relationship at the termination of adolescence, which will provide harmony for all the family members?*

During adolescence, the youngster fights against his dependent relationship with his family in order to achieve personal integrity and self-determination. Once he has won this battle for himself, he is able to return to a relationship with his parents, not as a child but as an adult. He can accept their counsel and advice without feeling dependent upon it or compelled to follow it. He can feel the gratification of seeing them lean upon him for advice or help as needed. Now no longer fearful of being a dependent child, he can express his affection and gratification for what they have done for him. As he begins to assume a marital and parental role for himself, he can understand more deeply the devotion of his own parents and return in some measure the affection that has been given to him.

# ADOPTION

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## ***What are some of the implications of adoption for mental health?***

Adoption can offer one of the soundest and happiest solutions to emotional problems resulting from frustrated basic needs of parentless children, childless parents, and those who cannot fulfill the role of parent for the children they have borne.

Through adoptive placement, the parentless child is provided with the parental love, nurture, and family life that are so important for his healthy mental and emotional development. The childless couple, who would otherwise be deprived of parental experience, finds an opportunity for the emotional fulfillment of parenthood. Finally, by having their children adopted, those who cannot function adequately as parents, for a variety of reasons, can nevertheless provide for their children's future welfare. Relief from the responsibilities of parenthood, when they are (or feel) unable to carry them, can often prevent overburdening their capacity for life adjustment; for many this makes it more possible to become successful parents in the future.

Adoption has wider mental health implications as well. The very fact that three segments of the population have been helped to achieve a happier, more mature life adjustment entails favorable reverberations within the community network of human interactions.

## ***What facilities does the community provide to bring about and safeguard adoptive placement?***

Couples who wish to adopt a child can best fulfill their own needs, as well as the needs of the child, by contacting an agency that has been authorized by their state for this purpose. In most states, the licensing, setting of standards, and periodic supervision of the adoption services provided by public and voluntary agencies is the responsibility of the State Department of Social Welfare. These agencies are supported through voluntary contributions and/or the allocation of tax funds.

Adoption work is carried on by many such agencies, in which it may

be the sole or one of several activities. For example, all services that accompany adoption may be undertaken by a single agency, or they may be divided among several collaborating agencies, i.e., children's agencies, family counseling agencies, shelters for unwed mothers, etc.

Whatever its operational structure, by virtue of the services it performs, the authorized agency represents the community's stake in implementing suitable and safe adoptive placement. First, the agency offers maximum protection of the identity of both the natural and adoptive parents as confidential. Second, the adoptive parents are assured that the child is legally separated from his natural parents so that placement will be secure and stable on that score. The adoptive parents also gain security and guidance for the future, from the agency's appraisal of the child to be placed, and his care prior to placement. Finally, the careful screening of adoptive parents provides maximum protection for the child that a suitable home has been selected for him. Thus one might describe the primary functions of the authorized adoption agency in terms of its efforts to bring about and safeguard the benefits to be derived from this remarkable human experience.

*What are the current ratios of adoptable children to prospective adoptive parents?*

According to statistics published by the United States Children's Bureau, 102,000 petitions for adoption were filed in 1959. Approximately 50 per cent of these children were adopted by relatives. Of the remaining number, 61 per cent were placed for adoption by social agencies; 39 per cent were placed independently.

Although, for obvious reasons, statistics are not available on the number of couples who attempt to adopt a child, some agencies estimate the current average ratio of adoptive children to couples who wish to adopt a child as one to seven. The picture is very uneven, however, for the country as a whole. A current trend toward a lower ratio is discernible. To a great extent, this disproportion can be attributed to the fact that most parent-applicants want to adopt "normal, white infants." As a result, there aren't enough adoptive homes available for many of the children who could profit most from the security of family life—older children, children with physical or emotional handicaps, children whose hereditary backgrounds might raise fears as to their future development, children of mixed parentage, and those who belong to minority groups.

In fact, for these children, the ratio might almost be reversed. That is,

despite the large number of prospective parents who apply to agencies each year, on the average only one adoptive home might be considered potentially available for every seven children who could not be classified as "normal, white infants."

Actually, in the past, few agencies made a serious effort to place such children for adoption. Today, however, a child's adoptability is more and more considered to depend on his ability to become a part of a family, that is, on his emotional capacity to benefit from family relationships, and in turn to contribute to the happiness of his adoptive family. It also depends on the agency's ingenuity, persistence, and judgment in finding the right family for such a child, and often in helping to overcome remediable defects as well as to allay groundless fears. The agencies that have developed intensive programs for such children have found that the adoptive situation has frequently proven particularly rewarding for both the child and his adoptive family.

***What is the major source of adoptable children?***

Ninety per cent of the children referred to agencies for adoption are born out of wedlock. The remaining 10 per cent are children of married parents who are referred for adoption for a variety of reasons. For example, according to a recent survey, in 4 per cent of these cases the parents stated that the child "was not wanted." Other reasons given were economic insecurity, 3 per cent; desertion of one parent, 2 per cent; and death of one or both parents, 1 per cent.

***How have mental health concepts influenced adoptive practice?***

Adoptive practice is geared to serve the closely interwoven needs of three sets of clients—adoptive parents, adoptive children, and natural parents. As far as possible, the specialized help provided strives to harmonize the psychological interests of all three. However, if conflicts between them cannot be resolved, the best mental health interests of the child must prevail.

In line with this focus on the psychological well-being of the child, who cannot act on his own behalf, agencies have accepted the recommendations of specialists that the child should be placed, at as early an age as possible, with adoptive parents who are capable of fostering his healthy development. Early placement coincides with the emotional needs of many adoptive couples who thereby more closely approximate the complete experience of having one's baby from the beginning. Early placement is often, but not always, in the best interests of the

natural parents as well, depending on the emotional ability to reach a stable decision.

Counseling and other social services for natural parents, and evaluation of and counseling adoptive applicants from the standpoint of emotional well-being as a family, exemplify the ways in which mental health concepts have come to permeate adoptive practice.

If the child is well beyond infancy when he is surrendered for adoption, every effort should be made to prepare him psychologically for adoption and to help him surmount the effects of the unfavorable experiences he will inevitably have been exposed to previously, so that ultimately he may profit from family life.

The wide range of mental health services entailed in the promulgation of these adoptive goals are the responsibility of the agency's staff of caseworkers, who have been trained in psychological concepts, with particular emphasis on adoption practice. Usually a psychologist is also a member of the mental health team. In addition, since caseworkers engaged in adoption work deal with some of the most profound and powerful forces underlying human relationships, most agencies have access to one or more consultant psychiatrists for advice about policy questions as well as specific problem situations.

*Shouldn't agencies make every effort to encourage natural parents, both married couples and unwed mothers, to keep their children, in order to prevent psychic trauma from permanent separation?*

If married parents decide to place their child for adoption primarily because of external factors beyond their control, such as severe financial reverses, illness of either parent, etc., the agency will make every effort to mobilize appropriate community resources, including temporary foster care, to help them keep the family together. Unless so motivated, however, the very reaching of such a decision by a married couple is usually found to indicate serious unwillingness or inability to provide a homelife for their child that would not endanger his healthy emotional development.

In contrast, although many unwed mothers have strong feelings of attachment to their babies, their frequent unreadiness for parenthood, intensified by the harsh social realities entailed, makes it inadvisable for most of them to keep their children. In most instances, an unwed mother can ensure a healthier future for her baby through adoption.

In our society, illegitimacy carries with it a variety of psychosocial

problems. First, both the unwed mother and her child may face social stigma, although this varies in degree between the many subcultures in the United States. Second, since she is likely to be burdened with having to provide support for herself and her child, the youngster would probably be entrusted to the care of other family members, or a succession of strangers, whose suitability for this task is often very poor.

Third, it is far preferable for every child to have two parents with whom to experience the benefits of family life. His relationships with mother and father affect different areas of his personality organization at different stages of his development. They are each of overall importance for his future adjustment, as is the quality of their marital relationship.

Finally, the task of rearing a child under these extremely unfavorable circumstances is likely to have far-reaching adverse effects for the mother as well. Resentment of her child, for example, as well as tormenting guilt feelings toward him, whether conscious or unconscious, are prone to mount, which further impedes the needed straightening out of her own life adjustment, and reduces her ability to function as a mother.

Some unwed mothers strive to solve their conflicts about keeping or giving up the baby by placing him "temporarily" in foster care. Without suitable concomitant counseling help, this is not likely to solve conflict, and all too often the placement lengthens into years. Experience has shown that there is little likelihood that the child's natural mother will be able to "work things out" and make a home for him in the near future, despite her good intentions. Moreover, this misconception can be extremely self-damaging to her efforts to begin her life anew. The consequences for the child are even more damaging. For throughout his childhood he is in a kind of confusing vacuum; he has a mother who isn't his mother; and, he lives with parents, or a series of parents, who are not his parents. Without a permanent home his personality development and sense of emotional security will suffer.

A recently published study, *Children in Need of Parents*, by Henry Maas and Richard Engler confirms the dangers of prolonged foster home placement. These authors found that there is a likelihood that children who have remained in foster homes for more than eighteen months will never return to their natural parents. Nor will such children be placed for adoption. Instead they will spend the rest of their childhood in limbo so to speak, in an environment, and among a family or families of which they can never truly become a part.



***Why is permanent adoptive placement, at the earliest age possible, considered important for the child's future development?***

Mental health specialists are agreed as to the vital role of early human relationships for healthy growth and development. Nowadays, for example, the importance of steady, affectionate, "good mothering" during infancy and early childhood has gained such widespread acceptance that the phrase "tender, loving care" has become a cliché. This concept has been substantiated by scientific evidence, accumulated by such experts in the field of child development as John Bowlby and René A. Spitz, among others.

Over a period of years, Bowlby has studied the effects of "maternal deprivation" on groups of young children who, for a variety of reasons, were separated from their mothers and placed in institutions. If they remained in such institutions for a prolonged period of time, Bowlby found that a small but significant proportion of the children observed "sustained serious damage," not due to active cruelty, but to the impersonal nature of such congregate care. On the basis of this finding, he concluded that if a young child must be separated from his own mother, it is essential for his future development that he be provided with a substitute mother from whom he can experience pleasure and security.

René Spitz's research, along similar lines, produced similar findings. However, in addition to disturbances of emotional and intellectual response, after they had been deprived of individualized affectionate care for an extended period, some of the young children in this group developed a physical apathy and listlessness that could have proven fatal. From this and much other work, there is a great deal of convincing evidence that deprivation of consistent affectionate maternal care and appropriate stimuli during the early years of life can have serious consequences for the mental and physical well-being of the child; by the same token, favorable experiences and relationships in early life foster growth and development. Mental health experts believe, therefore, that efforts to provide the child with a healthy "psychological endowment" should begin as early in life as possible.

Erik Erikson's concept of the development of "ego identity" is applicable here. Erikson regards "ego identity" as crucial to a healthy personality. He defines it as a "sense of identity, continuity, and distinctiveness . . . a sense of who one is, of knowing where one belongs, of knowing what one wants to do . . . a sense accrued throughout the stages of childhood that there is continuity, sameness, and meaning to one's life history." During the earliest stages of life, the infant

gradually acquires a sense of identity as a result of the fact that his needs are repeatedly satisfied by adults whose warmth and love for him can be believed in. This "sense of basic trust in existence," according to Erikson, is considered the earliest criterion of healthy personality development.

Of relevance to the optimum age for adoptive placement, Spitz, in the course of his researches, found that the infant cannot yet perceive and distinguish the mother as a particular individual during the first few months of life, even though he is so dependent on the mothering experience during that period; he has not yet developed the capacity for specific relationship to another person; as long as he is tenderly, consistently, and continuously cared for, his mother is interchangeable with any other person. However, after the age of about six months, the infant has learned to recognize his mother as a unique individual. He therefore reacts with anxiety to separation from her, and to being with a stranger. If intense and prolonged, this separation anxiety may be psychologically injurious to the older infant.

Establishment of the adoptive mother-infant relationship ahead of this developmental stage can be psychologically advantageous to the new parents as well as to the infant: partly because of the interdependence of their emotional well-being with his, partly because of their satisfaction of feeling him to be theirs from as near the start of his life as possible, and partly because the mother is spared the distress of the child's experiencing her, however temporarily, as a feared and hateful stranger.

To the extent that these observations accurately describe mental development, it would seem desirable to place infants for adoption well in advance of six months of age whenever feasible. Today, on the basis of the data accumulated in this area, many agencies place some infants for adoption as early as two weeks of age.

*Are children, whose adoptive placement is of necessity delayed beyond early infancy, permanently harmed psychologically?*

Several factors may delay the readiness of the child for adoption: The unwed mother may be unable to arrive at a firm decision to relinquish her child for adoption, even when there may be abundant reasons for such a decision. Her indecision may persist for an extended period.

Sometimes a child may be surrendered for adoption by his natural

parents only when he is already older, at a time when they become either unwilling or unable to adequately care for him.

Even when children are available for adoption at an early age, a history of certain hereditary illnesses in their background, or some indication of the presence of mental or physical deviation, or its possibility in the future, delays their adoption, in order that they be kept under observation at the agency for a period of evaluation and, upon occasion, treatment.

Agencies may also advocate delays in placement for most children who are referred for adoption when they are well beyond infancy, despite the fact that they may appear to be in prime physical condition. For it is inevitable that these children have been exposed to unfavorable emotional experience by the very circumstances that put them in need of adoption. The agency must attempt to assess the degree and nature of psychological harm sustained as a result. Such diagnostic evaluation is necessary for deciding if, when, and with whom adoptive placement is the plan of choice, as well as for helping toward the child's emotional repair and readiness for next steps.

Although postponement in adoptive placement, even for such reasons, does prolong the psychologically harmful condition of homelessness, this is offset by the greater likelihood of successful adoption gained thereby that protects both the children and the adoptive parents. It is urgent, however, to prevent delays in permanent placement due to such causes as outmoded or misguided precautions, community indifference, or procedural red tape.

One cannot generalize about whether and to what extent harmful psychic effects of early parental deprivation, prior to "delayed" adoption, are reversible or permanent. It depends on complex and numerous factors, specific to each situation, including differences in the child's early misfortunes, innate stamina, chance events, and the nature of adoptive experience. Some degrees of residual personality scarring may persist in certain adopted individuals, but not in others, which is true as well for the many nonadoptive children who experience some form of early trauma, often unavoidably. Significant permanent damage is not inevitable, because children characteristically have great resilience and ability "to bounce back" under conditions favorable to recovery.

Thus, although agencies try to expedite early adoptive placement wherever feasible, experts in the field have found that careful adoptive placement of the older child can be deeply rewarding for both the child and his new family.

***What mental health services does the agency provide on behalf of children who have been surrendered for adoption?***

The agency's mental health services to children vary in form and extent according to individual needs and the children's age, i.e., infants under six months, older infants, toddlers, and older children. Specialized mental health services per se include psychological testing for all age groups, psychiatric diagnosis and consultation, as needed, and intensive casework treatment and psychotherapy for some of the more troubled toddlers and older children. Indirectly, the greatest part of mental health service is given through applying psychological knowledge of child development and behavior throughout the entirety of basic adoptive procedures as carried out by the teamwork of agency caseworkers, pediatricians, nurses, and boarding-home mothers.

For young infants, the mental health services furnished by the agency are mainly diagnostic and preventive (of future maladjustment), the former through observation and assessment of their growth and development, the latter by means of warm individualized preadoptive care, and of course, in arranging suitable adoptive placement. If the infant's development does not seem to be proceeding properly however, the agency seeks the cause and provides treatment when possible. If the condition cannot be corrected, the agency may try to locate an adoptive family that will accept the handicapped child or if adoption is not feasible, the agency takes the responsibility for arranging some alternate plan for his care.

For older infants similar services are provided. In addition, however, they frequently need skillful extra care to overcome reactions of fear and grief. As mentioned earlier, after the age of about six months, the infant begins to distinguish his mother or substitute mother. Separation from her may mean an actual emotional loss for him, and may even result in a period of "mourning." Others who also need special reassurance and restorative care are those who reach the agency in poor condition from the effects of abuse or neglect.

Toddlers and older children require the services already described, plus intensive casework and occasionally psychotherapy. They need help in dealing with an unhappy past, a bewildering present, and an uncertain and frightening future. Adoptive placement is planned *for* infants, but it must be planned *with* toddlers and older children, so that they can ultimately "adopt" their new parents as well as be adopted by them.

When they reach the agency these children almost invariably feel

rejected and cast aside by their natural parents. In grasping for reasons they often blame themselves. Afraid, lonely, and helpless in a hostile, rejecting, and untrustworthy world, the longing for love in these children may be submerged and disguised by various reactions of anger, fear, guilt, mistrust, or apathy. Some who were exposed to a succession of changing worlds, as they were shifted between natural parents and perhaps several sets of foster parents, show problems of ego identity, in Erikson's sense.

The agency caseworker establishes a relationship with the child through which to understand and evaluate his difficulties as well as to help him overcome them. The relationship also provides transitional support, and conserves and nourishes his capacity to form a healthy attachment to new parents, who this time will be "for always."

In most agencies, until these children are "ready" for adoption, they are cared for in foster homes that are under the supervision of the agency; the environment therefore can be adjusted to the particular needs of each child.

Since the future healthy development of the child may well depend on whether he is able to relate to family life, the agency's efforts are geared to helping him achieve this. The caseworker not only prepares him for placement but continues to be available for support during the initial adjustment after placement.

These remedial measures are based in part on the fact that a child's attitudes and behavior patterns are not all firmly fixed as yet, but are in a constant state of flux; as such, those that are symptomatic of emotional problems may still be malleable and capable of constructive change in response to healthy experiences and relationships.

***Is the unwed mother who contacts an adoption agency emotionally maladjusted or delinquent?***

The majority of unwed mothers who come to agencies for help are very young, ranging in age from sixteen to twenty-two and tend to comprise an increasing number of teen-agers. Otherwise they differ widely in personality makeup, emotional health, intelligence, socio-economic and educational background, family relationships, and current life situations including the relationship to the putative father. In fact, unmarried mothers might be said to have only one characteristic in common: they have all borne—or are about to bear—a child out of wedlock. Consequently, there is a wide range of difference as to how

and why this came about, what the experience means, and how it may affect their future lives and those of their babies.

Emotional immaturity and varying kinds and degrees of emotional maladjustment frequently underlie the behavior resulting in the pregnancy. Contrary to some popular misconceptions the greater number, far from being "oversexed," are psychologically inhibited from full sexual responsiveness. Although defiance toward the rules of society and a high degree of impulsivity are prominent in some of these girls and women, which might be considered consistent with some forms of delinquency, they seem to be more a part of a personality disturbance.

Since the unwed mothers who contact the agencies range, from the standpoint of mental health, from the relatively healthy, to the seriously ill, it follows that the underlying reasons for their deviant behavior are multiple. Some of the recurrent psychological factors on which it is based have been found to include: feelings of loneliness and a bid for love; feelings of feminine inadequacy and an attempt to prove attractive and physically normal; mixtures of rebelliousness and guilt feelings toward parents with the wish to punish either or both or herself; naiveté and inability to say no; curiosity and experimentation, deeply rooted maternal longings entangled with conflict and fear; and an acting-out of unconscious fantasies.

Whatever the main psychological basis for her unmarried motherhood may be, in each instance it has great bearing, along with her degree of emotional maturity and personality health, on the kind and amount of psychological help she needs, for her own sake and for that of her baby.

*To what extent does the agency attempt to anticipate and satisfy the psychological needs of unwed mothers while also fulfilling its responsibility for the children?*

Most unmarried mothers first come to an agency mainly for some form of practical assistance. The caseworker will help with such pressing problems as financial assistance, employment advice, medical care, living arrangements, etc. Preferably, the same caseworker will continue to work with the client throughout her contact with the agency; as their relationship develops, the unwed mother's troubled feelings and deeper emotional needs may emerge so that the caseworker comes to provide more psychological help as well. Frequently, casework help to a young mother is greatly enhanced by occasional or regular interviews

with one or both parents, or other key relatives, but only when the girl herself wishes it. As already stressed, the nature and extent of caseworker help, sometimes aided by psychiatric consultation, varies greatly in view of the broad mental health spectrum occupied by these girls and women.

Many are children, emotionally and socially, whose strong dependency needs are accentuated by their frightening and confusing predicament. Of these a substantial number are chronologically still children as well. They often need guidance, protection, and reassurance, as well as constant emphasis on realistic thinking, in place of irrational fears, wishes, and self-defeating evasions as the basis for behavior and decision-making. By contrast some of the unwed mothers have considerable resources of inner strength; sometimes their distress is the more acute because of their capacity for depth of feeling and their sense of responsibility.

For some, a maternity shelter provides an optimal resource in which the general atmosphere reflects rehabilitative goals and mental health principles, in contrast to the earlier punitive attitudes that often prevailed. Such shelters may be run by the agency itself or cooperate closely with it. Group therapy at the maternity shelter can be another mental health service of value to some unwed mothers, and has been especially helpful to some of the teenagers among them.

Regardless of their many differences, all the unwed mothers face the necessity of planning for the baby after its birth. It is by helping the mother in her struggle toward a decision that the agency can simultaneously fulfill its responsibilities to both mother and child. For, as already stressed, if a child is to be adopted, it is far better for his future that he be relinquished for adoption as soon after his birth as possible. It is also far better for the unwed mother's future well-being that she neither feel forced abruptly to relinquish the baby without first reaching as much emotional readiness as possible, nor that she bog down in indecision, thus prolonging her guilt feelings and conflicts, and intensifying the eventual pain of separating from the child she cannot raise.

It is most advisable that the agency's counseling services be available to the unwed mother as early in her pregnancy as possible. As indicated above, the casework relationship takes time to develop before meaningful psychological help is possible, so that it should have been under way well in advance of the birth of the child in order to be of maximum use immediately thereafter. In fact, for some of the more psychiatrically

vulnerable unmarried mothers, with excessive anxiety, conflict, and guilt feelings, this supportive relationship may prevent a severe post-partum depression, such as occurs for some of those with similar difficulties but without such assistance.

Use of counseling in this way illustrates that it is by no means limited to the decision about the baby, despite the central importance of this; it would be impossible, since the feelings involved are far too intimately enmeshed with the whole of the young woman's personal life, past and present. Rather, the caseworker relates to the unwed mother in terms of her total self and her life situation. Frequently this may entail painfully contradictory feelings with respect to the putative father and the unwed mother's own parents, as well as toward the unborn baby and herself. Similarly, the caseworker relationship and the working through of her feelings, prenatally, about placing the child, provides a base of support for the moment of actually relinquishing the baby after it arrives, which otherwise might stimulate damaging reactions; these could include an impetuous reversal of the decision, which even though temporary, may last long enough to hurt the child, and make it harder for the mother. The carrying out of the decision, even though it is realistic from every point of view, cannot help but be accompanied by some measure of conscious or unconscious regret and sadness, as well as self-reproach, except by those whose emotional makeup is markedly deviate.

From the standpoint of the unmarried mother's future, the agency's mental health services may not only have prevented greater maladjustment, but in a positive sense may have contributed to an improved adjustment, by helping this life event to become a maturing experience with increased insight into motivations and thus control of behavior, making recurrence less likely. While it may seem ironic, for some of those with long-standing, but untreated emotional disorders, the symptom of pregnancy forces them into long-needed contact with appropriate psychological help and thus may alter the future course of their lives for the better. Obviously, if unwed mothers are not referred to authorized agencies, as occurs when adoptions are arranged independently, they are deprived of such services.

***Is the agency likely to come in contact with the child's putative father?***

In many cases the unmarried mother and the putative father will have known each other only briefly, and very often the woman will try to forget that the man ever existed. The majority of men fear involvement. Even in those instances where their relationship has been



more stable, the putative father's sense of responsibility toward the unwed mother and his child is often outweighed by his fears of contacting the agency. These may include fears of being blamed, of legal paternity proceedings, and if already married, of disclosure. Actually, the agency is ready to see him, if the mother wishes it, with assurance of full confidentiality.

Occasionally, fathers do contact the agency, either to participate in planning, to offer moral or financial support to the mother, or to furnish background information, which is extremely useful in connection with evaluating and placing the child. Sometimes troubled putative fathers, some of whom are still minors, turn to the agency for help with their own emotional problems, including conflicts about marrying the mother. Although neither they nor the unmarried mothers, in many such instances, are psychologically ready for marriage, or appropriate for each other, especially under such conditions, the father's willingness for involvement, however limited, often comforts the unwed mother, helps to reduce his own anxieties, and bolsters his self-respect.

The agency's casework help is available to putative fathers who seek it, and in some instances, these services or appropriate referral for psychiatric treatment, may prove of far-reaching benefit to them.

*Since "independent adoption" lacks the many mental health protections agencies provide, how can more children for early adoption be placed through authorized agencies?*

Many natural and adoptive parents turn to individual intermediaries rather than to authorized agencies for arranging adoptive placement. As noted above, about thirty-nine per cent of children adopted by nonrelatives in 1959 were placed independently, i.e., either by their parents or relatives, or through intermediaries. The practices of the latter cover a wide range, from illegal black marketeering, through varying shades of ethics, good intentions, and ignorance, to those responsible physicians with sincere convictions that they are as well or better qualified than agencies, and who see this function as an obligation to patients. Their argument gains added force in some sections of the country where available agency resources are still inadequate in terms of quality and quantity. In conjunction with nationwide efforts to correct such inadequacies of adoption facilities, and to strengthen legal safeguards of adoption through legislative reforms, the medical profession is increasingly recognizing, officially, that the

physician's many essential direct and indirect medical services in adoption (obstetrical, pediatric, advisory, etc.) are best carried out in cooperation with an agency whose specially trained staff should undertake the necessary investigations of the various parties and the actual placement of the child. This is borne out, for example, by the article, "Adoption of Children," American Academy of Pediatrics, 1959.

Although independent adoptions may indeed turn out very well, in spite of the absence of agency services, this is often due to luck, while all too many others incur preventable unhappiness or tragedy. Of course, agencies too make mistakes, but their percentage of error is much less, and they keep improving their practice, in relation to advances in knowledge as well as better budgetary support.

In addition to factors of legislation, agency availability, and physicians' attitudes, the psychological reasons why many natural and adopting parents turn to nonagency adoptions are many and diverse. (Some will be touched upon in reply to subsequent questions.)

One causal vicious cycle, however, applies to the question at hand: about seventy-five per cent of the children who need adoption by non-relatives are born to unmarried mothers. Authorized agencies are best qualified to help cope with the emotional crises that accompany unwed motherhood. When unmarried mothers, however, fail to reach the agencies, in many instances their infants are diverted into nonagency adoptive channels. With too few of the babies eligible for adoption under their care, the agencies are forced to refuse, and thus antagonize, many suitable prospective adoptive couples desiring infants; in reaction, many such couples feel driven to independent adoption rather than risk long waiting and possible disappointment. They in turn help create the very "demand" for independent adoption of infants that tends further to maintain this practice.

Clearly, in order to break into the vicious cycle so that more early placements can have the advantages and safeguards of agency services, efforts must begin at the point of advising the unwed mother. She should be made aware of the community facilities that are at her disposal, and should be helped to understand the advisability for herself and her baby of utilizing such services, as opposed to independent channels. One of the best persons to explain this to the unwed mother is the physician who diagnoses her pregnancy, and who is often her first confidant. In a 1958 pamphlet, the United States Children's Bureau defined the physician's responsibility toward the unwed mother to include referral to an appropriate social agency, or in the absence of a

local agency, to the State Department of Social Welfare. The pamphlet was formulated with the help of leading physicians of several specialties from different sections of the country. It stresses the special value of the rapport between the physician and his patient in preparing her "psychological readiness" to accept agency help for her emotional and environmental problems. (He will continue to care for her medically, unless alternative arrangements are preferable.)

Through such auspicious and prompt referrals of unmarried mothers, more infants for whom adoption is the best plan, can have the mental health advantages of early permanent homes, with agency protections.

***Once a couple considers adopting a child through an authorized agency, what are the procedural steps?***

Adoption is a gradual sequential process rather than an event. Upon receipt of the couple's expression of interest, many agencies, either through written materials or group meetings explain some of the philosophy and facts regarding adoption, including information about the available children and about the purpose and nature of agency procedures. The group meeting method (attendance is optional) includes the advantage of answering questions, which further helps to clarify what may be expected, realistically, and to dispel some of the illusions that prevail about adoption.

If the couple decides to go on, a series of screening procedures follow. Although agencies differ to some extent, as in the use of written questionnaires, number and spacing of interviews with husband and wife, together and separately, the time intervals between the various steps, etc., the general pattern includes intake study, and then for those who continue, home study; if home study has confirmed the advisability of a couple becoming adoptive parents, there is a variable waiting period while the agency selects a child considered appropriate for that particular home. The child is described to the prospective parents, and if interested, they may meet him one or more times. If everything goes smoothly, placement, supervision (a period during which the agency still carries responsibility to assist the placement and to see that all goes well), and finally, legal adoption follow. Throughout these steps, screening goes hand in hand with a process of helping the couple prepare for the actualities of adoption.

The above applies to those who are adoptive parents for the first time. When couples reapply for a second child, the focus of the study

is on the period since previous contact with the agency, and includes evaluation of the relationship between the couple and the first adoptive child, as well as the child's development and adjustment.

*In general, what are the criteria of eligibility for adopting a child?*

In selecting from among the adoptive homes for children under their care, agencies nowadays give the greatest weight to those personal qualities that make for "capacity for parenthood." As a general rule, the capacity for warm, mature love for a child as an individual in his own right, by each parent, and by both as a unit, plus a compatible, stable marriage, are accepted as the mental health prerequisites for any adoption, whatever the age of the adopted child. In addition, adoption agencies give high priority to the applicants' adaptability, flexibility, and their ability to cope with the unpredictable vicissitudes of life.

Agencies do not look for some single personality stereotype or hypothetical paragon of perfection among adoptive applicants. They know there are multiple patterns and styles of life through which basically positive human experience may be lived. Similarly, aside from protecting the child against foreseeable extreme economic deprivation, children are placed with adoptive parents who cover a very wide range, financially; the same is true socially and educationally.

Eligibility requirements as to the couple's religion vary among different denominational, nonsectarian, and tax-supported agencies. The agencies in turn are subject to widely differing laws and their interpretations in various parts of the country. According to the Child Welfare League of America's *Standards for Adoption Service* (1958), natural parents have the right to determine the religion in which they wish their child to be reared, and "placement of children should not be restricted, in general, to homes with formal church affiliations." These principles differ, in certain respects, however, from those held by the Roman Catholic agencies whose statement, also included in the published "Standards," regards the religious status of the adoptive couple as "the weightiest, although not the sole element . . . among the several important factors . . . in successful adoption."

In addition to the fundamental attributes for all parents which are conducive to the child's healthy growth and development, and which agencies seek for the children they place, there are some psychological qualifications specific to adoptive parenthood. Perhaps the most important of these relates to the couple's inner ability for successfully transposing their parental urge from the biologically conceived child

they desired to the adopted child as an accepted substitutive solution. For the wish to adopt (except when based only on extraneous motives, and this would contraindicate adoption) is ultimately rooted in the reproductive drive, with its associated parental feelings. Adoptive applicants cannot therefore demand of themselves, nor do agencies expect, that adoption must represent their primary choice. If however, their feelings cannot move on to the adopted child comfortably and completely enough, with minimal persistent anxiety and conflict, this does not detract from their worthwhileness as people, nor signify maladjustment per se, but it does jeopardize the mental health outcome of the adoption. Such adoptions should not take place since the parent-child relationships, and hence the child's development, will be bound to suffer. (Sufficient acceptance of adoption does not mean that couples need drop all interest in having a child biologically in the future; their parental aspirations, however, would not any longer be fixed exclusively on this form of fulfillment.) Various unresolved emotional problems around their inability to bear children may obstruct a couple's sufficient deep down acceptance of adoption for a satisfying experience by the child or by themselves. The child is too prone, for example, to represent a constant proof of painful defeat and deficiency.

Accordingly, in addition to assessing general parental capacity, exploration of these and related issues through interviews is important to the agency and to the prospective adoptive parents. Since, by the very fact of applying, most of the latter regard themselves as already decided about wanting adoption, the screening procedures must probe, with the couple, below the surface for subtler and often less conscious attitudes and conflicts that are relevant. This can be distressing at times, and calls for skill, objectivity, and tact on the part of a highly trained agency staff, and self-searching honesty on the part of the parent-applicants. Even so, it occasions some of the resentment toward agencies that leads some prospective adoptive parents to prefer the less "inquisitive" intermediaries of independent adoption. This may indeed increase their immediate comfort, but all too often at the expense of their long-term welfare and that of the children they adopt.

***Do agencies set arbitrary age limits and physical health requirements for adoptive parents? Do parental criteria differ for adoption of older children and children with other special needs?***

On the whole, it is felt that adoptive parents should be approximately the same age as a child's biological parents. If a childless couple

well into middle age, for example, were to adopt an infant, no matter how exemplary their other attributes as potential parents, their relationship with the child would be at a disadvantage in several ways. As he grew older they would be more appropriate as his grandparents. Some lack of rapport would be likely to stem from this spread of years between the child and themselves, increasing as the age difference between them increased, with respect to attitudes, interests, and approaches to life.

Also, such a couple has gone past the life epoch when the necessary energy and endurance for taking care of a young child is usually available, without overexertion, that it may impair the child-parent interactions. Furthermore, a husband and wife's good adjustment to childlessness, evolved over the years as a "twosome," may be thrown off balance by belated conversion, through the advent of a child, into a threesome, even though originally, their lives might have been happier with children. Moreover, childless couples well along in life are likely to have become "set in their ways," without the desirable degree of flexibility for coping with a young child. They may, therefore, lose patience with him too quickly, or tend to impose excessive restrictions before he is really able to control his behavior.

Individual differences in couples of the same age are recognized, of course. Agencies much prefer to maintain flexible policies for appraising each situation individually; many of them have set age restrictions with reluctance because of the disproportion between available infants and applying childless couples, whereby many of the latter would have to be refused; it seems more fair to do so on grounds that statistically at least, have a relevant rationale. As more babies are adopted through agencies and the disproportion is reduced, such agencies lower their arbitrary age limits.

The factor of age is also pertinent, however, with respect to the adoptive parents' life expectancy in relation to the age of the child they adopt. Authorized agencies strive to protect the children they place as much as possible against risks of losing their parents for a second time, due to death or incapacitating illness. They require, therefore, that applicants be examined by their own physician, who submits a report of their medical history and his findings, or by a physician working in conjunction with the agency.

There is more latitude about age limits in the placement of older children, however. Not infrequently older couples may decide to adopt a child after their own children are grown and have left home. These

placements are often highly successful; such parents are experienced in child rearing, and "know what to expect," so that, in general, they can be more relaxed in dealing with the special problems that older children may bring to the new adjustment. Also, because their self-confidence as parents has been firmly established already, they can better tolerate with understanding, and need not take personally, such typical reactions of older children as provocative misbehavior to test the reliability of parental love, or the clinging to their past memories as they face the unfamiliar new life. Because they are not dependent on the adopted child for the totality of their parental fulfillment, such parents have less need to overtax a child with expectations beyond his capacity, which could be a source of mutual unhappiness. Many deeply satisfying relationships are experienced by these older couples and older children who "adopt each other."

Similarly, couples who have already adopted one or two babies are ineligible for more, according to the current policies of most agencies, although this restriction does not obtain for the hard-to-place children with special needs, i.e., children of mixed racial background, older children, sibling groups placed together, and children with physical or mental handicaps.

In placing such children, agencies generally modify all regulations about ineligibility that do not compromise basic essentials. Thus, emotional acceptance of the adopted child remains as a criterion for all applicants, whereas intake policies with regard to religious backgrounds and beliefs, except in Catholic and some church-related agencies, become secondary to the needs of these children for suitable permanent homes.

*Would the fact that either or both applicants had undergone emotional deprivation in their own childhood, or had ever received psychiatric treatment preclude their eligibility as adoptive parents?*

The degree and nature of emotional deprivation the applicant may have been exposed to in the past is only of consequence with regard to whether and how it may have affected present capacity for the role of adoptive parenthood. The crucial assessment, for the agency, is limited to the applicant's present attitudes and behavior with respect to how he or she can relate to and nurture an adopted child despite having experienced rejection, harshness, or disturbed family relationships in childhood.

Similarly, a history of psychiatric treatment merits exploration but

does not necessarily disqualify. On the contrary, depending on the difficulties that prompted the treatment, and its outcome, it may be recognized as an asset for adoptive parenthood. Psychoanalytic treatment, for instance, may have helped an applicant to a degree of self-awareness, resolution of conflicts, and personal growth that improves the prospects for favorable adoptive experience. On the other hand, when the disorder requiring treatment was such as to impair parental potential, and symptoms persist, or there is appreciable risk of recurrence, adoption would be deemed unsafe for the child's development. Placement of a child as psychological "therapy" for such a would-be parent, as sometimes urged by well-meaning advisers, both lay and professional, violates the agency's responsibilities to the child, and has proved to be poor medicine for the patient.

If a prospective parent is receiving psychotherapeutic treatment during the course of applying for an adoptive child, the agency, in appraising the couple's current life situation will naturally be concerned with the nature and severity of the problems that occasion treatment. Sometimes the treatment process itself absorbs so much of the applicant's emotional attention that it may be advisable to postpone adoption for a time, until a greater proportion of emotional energies can be freed for the new relationship with a child. An added advantage from such delay is the greater leeway to explore and test shifting motivations and attitudes about adoption during treatment before the couple ratifies its wish to adopt.

Agencies strive to "screen out" those psychological attributes of adoptive parent applicants that have proved damaging to child development and to "screen in" those found to be growth promoting. It would be foolish and impossible to aim for adoptive parents who are "mentally healthy" in every respect. There are no such people. In fact, the very term "mental health" is remarkably hard, if not impossible, to define completely when differences in cultural norms and values, for example, are taken into account. By and large, agency screening is based on a relative rather than absolute conception of mental health: not total absence of neurosis, for example, but what kind, how much, and how does it concern adoptive parenthood, is at issue. (See *Mental Health; Optimum Mental Health*)

***What are some of the reasons underlying a couple's decision to adopt a child and their implications for successful adoption?***

The great increase in the number of adoptions over the past decades may be attributed to a variety of factors. First, the great value



placed on children in our society has given rise to the feeling that a childless couple is "incomplete" as a family unit. Second, changed social attitudes have made adoption much more acceptable; it is associated with far greater frankness and enjoyment, nowadays, than with the former degree of secrecy and shame.

In obvious and overall terms, every applicant-couple seeks to adopt because it wants a child and either cannot, or for medical reasons should not, bear a child of their own (very occasionally an applicant consciously prefers adoption to childbearing). Many complex and individually varied motivations, however, underlie these broad common denominators; the subsurface reasons relate so closely to what an adopted child would really mean to a couple, and thus to the crucial parent-child relationship, that a searching effort to understand them is important.

To begin with, the very factor that has brought the adoptive parents to the agency—the failure to have children of their own—merits careful exploration. Thus, the agency attempts to ascertain the reasons for the couple's childlessness, what it means to the husband and to the wife, how it has affected their feelings toward themselves and to each other, and to what extent, and in what ways these feelings have influenced the decision to adopt a child.

Once in a while, couples who are presumably fertile prefer adoption. Some are afraid of transmitting an inherited defect; in such instances appropriate consultation helps to evaluate the actual risk. Others sometimes seek to bypass what may unduly frighten or repel them about the normal reproductive process. In general, it is unwise to act upon unrealistic fears, even though they may be compelling, especially when, as in adoption, the action involves several lives, and permanently. In contrast, appropriate reassurance, and in some cases, psychological help, may stimulate a train of events within and between the applicant husband and wife whereby their application leads instead to bearing their own child. Couples for whom childbearing is medically forbidden, and couples who have borne children but want more, through adoption, after menopause, feel differently about their childlessness, of course, than those who are completely sterile (as from surgery), or relatively infertile from known or unexplained causes.

Inevitably, reproductive incapacity must have a strong psychological effect in terms of the individual's total personality. The question of whether the impaired fertility affects the husband, wife, or both, is of considerable significance. Experience has shown that adoption works out best for those applicant-couples who have reached a deep-seated ac-

ceptance of their infertility as a physical fact, for which neither partner need feel blame or shame. On the other hand, pronounced ongoing emotional involvement in their childlessness may prevent a mutually sound relationship with an adopted child. Thus, for some husbands and wives who experience their infertility as crippling to their sense of manliness or femininity, the adopted child is likely to represent a constant reminder of their painful defeat or shameful "deficiency." In such instances adoption would seem unwise.

Some couples turn to adoption as a first reaction to sudden bereavement. Ultimately this may prove a very sound solution. However, it has been found advisable for most such couples to postpone their decision until the acuteness of their initial reaction has worn off and wait until after a period of mourning. If they adopt immediately after the death of their own child, they may be unable as yet to relate to the adopted child as an individual in his own right so that he, in turn, must inevitably fail them as a replacement of their lost youngster. By waiting until really ready for a new relationship, these couples can avoid such unhappy complications as hostility toward the adopted child for surviving when their own child could not, or conflict in letting themselves love the adopted child from guilty feelings of disloyalty toward his predecessor.

Couples seek, through adoption, satisfactions common to all normal parents, among them, the desire to love and be loved by one's child, to care for and be proud of him, to enjoy his dependency and take pleasure in his achievements. In well-integrated combination, all these components of parenthood contribute to the child's healthy growth, and make adoption a mutually felicitous life arrangement. If, however, one of these parental ingredients predominates to excess in a couple's motivation to adopt, it may be detrimental psychologically. To illustrate, if a child's parents regard him primarily as a vehicle for improving their own social status or self-esteem, or so prefer his dependency that they prolong it through overindulgence or overcontrol, his development must suffer. Accordingly, sensitive scrutiny of parental motives in appraising adoptive homes increases the happiness that adoption can bring.

***Why should the "approved" adoptive procedure be so much more complicated than independent adoption?***

Nonagency or independent adoptions, as indicated previously, fall into two main categories: the baby-selling or black-market type that

exploits human need and suffering for financial profit; and adoptions that are arranged by well-intentioned intermediaries—friends, relatives, doctors, nurses, or lawyers. Many of these intermediaries sadly underestimate the complexity of their task and overestimate their own capacity to assume it.

Understandably, their placement methods appeal to some couples as simpler and often faster than agency service, with more certainty of getting a baby. But the desire to adopt, of itself, on the part of a reputable couple is not enough to ensure adoptive safety, from the mental health standpoint. After all, the highly charged emotions, motives, and personality attributes involved in adopting are indeed complicated; they are no less so when overlooked by intermediaries and the couples themselves, nor less influential on the tenor of ensuing family relationships, and thus on the child's healthy development and their own happiness.

*How does the agency help parent-applicants psychologically, at certain crucial phases of adoptive procedure?*

The psychological aspects of contacts between agency and adoptive applicants are important throughout the progression from their first expression of interest in adoption to its legal consummation, and sometimes even thereafter. As indicated already, the agency's screening functions are closely linked throughout with helping couples to adopt successfully by assessing the wisdom of adopting, recognizing and resolving problems that could cause trouble, and preparing emotionally for the realities of adoptive experience. The onset of the adoptive study, and the first time a couple sees a child whom they can adopt are among the specially crucial stages, psychologically, in the total sequence.

The beginning stages of study are unavoidably stressful for parent-applicants so that maximum consideration is called for on the part of the agency staff. Emotional tension is almost always present in early interviews, hence agency evaluation of a couple's attributes for adoptive parenthood must take this factor into account. The anxieties that beset applicants at this time vary widely, of course. Especially for those seeking infants, a frequent source of tension stems from the fear that their strong desire for a child may be thwarted and, at the same time, that they may be judged inadequate as parents, and as people. These feelings not only engender distress for the couples, but may temporarily obscure and distort the picture of themselves they present to the agency. Thus, an applicant may be overeager and unnatural in an effort to

make a "good impression," or overly modest and unassuming. In contrast he or she may be very hostile toward the caseworker in anticipation of rejection or from feeling affronted by "being judged." It is important that the agency distinguish from among the couple's reactions to the interview situation those which would bear on their role as adoptive parents.

Couples sometimes deliberately conceal or deceive to fit what they think, or have been told, the agency approves of. More often than not, this backfires. Although the caseworker may indeed be taken in by a specific distortion of the truth, she may pick it up in such forms as emotional tension, excessive pressure to control, evasiveness, and a general quality of falseness that arouse more questions about the applicants than if they had been candid in the first place.

Since interviews entail interactions between the couple and agency worker, the process must be protected from bias or personal reactions on the part of the caseworker. Major safeguards are the worker's self-awareness and constant vigilance on this score, which are professional attributes given central attention in her training and modes of practice.

The screening and helping process does not stop once the couple's application has been accepted. Stress reactions may persist or arise during subsequent phases as well, and the agency strives to relieve applicant anxiety whenever possible. Thus, occasionally, prospective parents are startled and distressed by reacting negatively to their first sight of the child that can become theirs. Instead of the surge of parental affection they expected to feel at this longed-for moment, they may become acutely anxious or experience a detachment, dislike, or active aversion. This in turn may arouse painful self-doubts and guilt feelings, or be rationalized as due to imaginary or exaggerated faults in the child.

Despite surface similarity such reactions may have different causes, with correspondingly different implications for the ultimate outcome of the adoption. Once in a while, on investigation, they prove to have been a belated signal that both the agency and the couple had been mistaken in believing that the latter basically wanted and could accept adoption. Occasionally the reaction turns out to mean that there is something about the particular baby, often subtle and intangible, that fails to appeal to this couple who, when shown another child, can and do fully accept him. More often, however, the initial negative reaction is found to be due to psychological causes that need not prevent successful adoption if dealt with understandingly.

Thus, childless husbands and wives yearning for a baby almost always

build up vivid conscious or unconscious fantasies of what their own child would be like, could they have borne one. Unwittingly, it may be this fantasy child they expect to find when they first go to see the agency's baby. Inevitably, since reality cannot conform to fantasy, they are abruptly disillusioned.

In another instance, a woman who is unable to bear children of her own (the example could also apply to a man) may feel brutally forced to face her barrenness as final when she sees the adoptive baby for the first time. Despite rational acceptance of the facts, secretly she had continued wishfully to expect to bear her own child some day, even when this hope was without realistic justification. The abrupt pain of realization sets off the whole gamut of hurtful emotions surrounding her childlessness. Understandably, she cannot immediately extend love simply and happily to the adoptive child, and this itself is cause for further distress.

Negative reactions may also stem from the fact that, while the natural parents have nine months in which to prepare for their baby's arrival, the adoptive parents are given only a few days' notice by the agency of a baby's availability. Although they may have had their application on file for months, to forestall disappointment they have not allowed themselves fully to count on the possibility that it would be accepted, or that a suitable baby would be found for them. As a result, they are relatively unprepared for the parenthood so suddenly thrust on them.

When reasons such as these underlie a couple's recoil at the first sight of the child, the caseworker's reassurance and explanations, combined with slowing up the process to catch up with their emotional pace, can often help very effectively.

*Is it true that, after adopting a child, couples are more likely to have children of their own?*

At one time or another almost everyone has heard of couples who were able to have children of their own once they had adopted a child, although they could not conceive previously, despite medical treatment. The relationship between these events is no longer considered mere coincidence, nor are such accounts regarded as mere "old wives' tales" by many scientists. For example, a majority of physicians, who were recently surveyed, believe that adoption can trigger pregnancy. A number of research studies are under way to investigate this more conclusively. Meanwhile, there is some evidence to suggest that emotional problems may be among the many intricate factors that influence fertil-

ity, and that the experience of adoption may entail some reorganization of the psychic life that in turn may facilitate conception.

*To what extent can agencies predict the future development of the babies they place for adoption?*

In evaluating the children for adoption, agencies gather as much information as possible about the family background, especially with respect to characteristics that may be of significance to heredity. Prenatal and birth history is also sought, as well as the health and developmental history of children older than newborns. Evaluation is based on this data, obtainable in varying degrees of completion, in combination with the findings of physical and psychological examinations, and observations of development. Consultation with a geneticist may be very helpful when special questions arise about predicting the impact of a child's heredity on his future, mentally and physically.

Each individual's development is the outcome of complicated interactions between inherited and constitutional factors on the one hand, and life experience and environment, on the other. There is no single overall answer to the much debated question as to whether nature or nurture has the greater formative power, since each specific trait must be considered separately in this respect. Different genes interact with different environments in different ways. Environment, in this broad sense of the term, refers to the totality of life circumstances including physical surroundings (prenatally, as well), human relationships, and acquired illnesses. Every human being begins life with certain unalterable characteristics, such as the color of his eyes and hair, his fingerprint pattern, his unique blood type, etc. He also carries within himself a genetic heritage of potentialities and predispositions that may become manifest at different stages of life, and in different degrees, or not at all, depending on the succession of environments he encounters.

With the important exception of certain serious inherited illnesses and congenital malformations, predictive accuracy as to the physical and mental development of infants is much more limited than is generally recognized. For the processes of hereditary transmission and genetic-environment interactions are incredibly complex. Regressive genes, for instance, as part of our "hidden heredity" may be carried without showing up for generations. Innumerable variables determine whether, when, and how a given trait within an individual's genetic endowment may penetrate or be expressed in his lifetime.

Oversimplification may be dangerously misleading. For instance, with regard to mental abnormalities there are many different forms of mental retardation and mental disorder; the role of heredity must be considered separately for each. (Some are not transmissible, but acquired through infectious illness or injury.) A good deal is known, that can be applied in adoptive practice, about certain inherited forms of mental deficiency and the ages at which they are most likely to occur. Not all cases, however, are predictable; thus, any couple, of average or above average intelligence, may also become the parents of a mentally retarded child, if both chance to be carriers of the same defective gene. On the other hand, the genetics of general intelligence, to which a host of genes contribute, are very different than for those forms of mental deficiency that are part of inherited neurological and metabolic diseases, or congenital anomalies. Mental ability, though definitely influenced by heredity, seems subject to even greater modification by the environment than most physical traits. Differences in energy endowment and basic temperament, as between placid and volatile, for instance, appear to be more inborn and less modifiable by the milieu than special proficiencies, interests, and such personal attributes as self-confidence and capacity for affection.

*Can adoptive parents be assured that inherited illness or defect will not manifest itself at some later date?*

Adoption workers are often asked, or ask themselves, "Is mental illness inherited?" The question has little meaning, in this form, since mental illness is not a single entity, but a collective term for many kinds of disorders, involving very different causes and combinations of causes. Personality maladjustment, various types of deviate behavior, psychoneuroses, and the many different psychotic illnesses, must be differentiated in considering the causative role of hereditary factors. Although much has been learned, there are still big gaps in our knowledge as to the origins of many of these conditions. There are also differences of opinion in interpreting the available evidence. For example, some authorities believe that a strong genetic component enters into the causation of schizophrenia. Others conclude, from the findings, that varying degrees of inborn vulnerability may be likely, at least in some cases, but attribute a greater causative role to stressful experience and psychogenic trauma, especially in early life.

It is generally agreed, however, that one cannot assume that a child,

whatever the psychiatric status of his natural parents, is bound to manifest some form of mental illness. It has also been well substantiated that emotionally healthy family relationships in childhood have significant protective power against inborn vulnerabilities. The Child Welfare League of America's 1958 *Standards for Adoption Service* states: "There are no hereditary factors that should automatically rule out adoption."

In striving to protect adoptive parents against undue risks of adoption, the agency does not aim at unrealistic guarantees of the child's perfection or its lifelong immunity to unforeseeable vicissitudes such as all parents must face. Instead, by evaluating the adoptive child as fully as possible, the prospective parents can be told as completely as present knowledge permits about his condition and future outlook, including special strengths and weaknesses, as these can be determined at the time. As stated in "Adoption of Children" (American Academy of Pediatrics, 1959), "It is well to remember that most adoptive parents run no greater genetic risks with their adopted child than they would probably have encountered could they have become natural parents." On the other hand, adoptive parents do have an advantage over natural parents in that the agency screens out children with discernible congenital defects or considerable chance of inheriting certain serious illnesses. Those adoptive parents who are willing, nevertheless, to accept some of these children do so knowingly and from choice.

Meanwhile, important and related new research findings in biochemical genetics, on the one hand, and behavioral sciences, on the other, are shedding new light on the nature of heredity-environment interaction at the behavioral level. Adoption agencies accept responsibility through their consultants and professional organizations for keeping abreast of relevant scientific developments so that adoption practice can continually improve.

*What are some of the considerations governing agency selection of a particular child and adoptive couple for each other? Is the matching of similar backgrounds and appearance important for suitable placement?*

Agencies assess the suitability of children and adoptive parents for each other on the basis of the fullest possible preadoptive studies of each. Naturally, "matchmaking" of infants and new parents is different than for older children whose personalities are formed enough to influence the subtle mysteries of mutual attraction. For older children



and parents adopt each other, in contrast to the placement situation of infants. Furthermore, as the potentialities of older children keep unfolding, their future physical and mental development may be estimated with somewhat greater accuracy. Psychological tests of infants, for example, are unreliable predictors of intelligence level; their value lies in helping to appraise the comparative normalcy of development as of the time when examined.

In the past much emphasis was placed on similarities, especially of physical appearance, as well as national, sociocultural, and ethnic backgrounds. It was thought, for example, that matching the child's hair color, physique, and complexion to that of the adoptive parents would facilitate the desired emotional identification between them. Experience has shown, however, that couples can identify with children whose appearance and background differ markedly from their own. Instead, optimal "matching" nowadays puts more stress on other kinds of correspondencies between the child's estimated potentialities and the parents' personalities, values, and modes of life. Respective temperaments, for example, are taken into account. Whether similarities or differences work out better depends on many factors, which also must be considered. High-strung, quick-reacting parents may provide healthy stimulus to an active responsive baby, but feel impatient and frustrated by a very placid infant who would fit better with a more easygoing couple. On the other hand, sometimes opposite attributes of parents and children supplement each other advantageously. A mother who is inclined to be tense might upset, and be upset more readily by, a sensitive, easily excitable child than if each could be paired with a calmer mother or child, respectively.

Since the child's "developmental potential" includes his hereditary endowment, effort is made to place him in an environment conducive to offsetting inherited vulnerabilities and fulfilling inborn capacities to the extent that these are ascertainable.

Within the current limits of predictability agencies try to relate a family's intellectual standards, expectations, and opportunities to the child's level of intellectual promise. If a child of average intelligence is placed with parents of highly superior intelligence, for instance, whose cultural expectations are too far beyond his reach, mutual disappointment and emotional stress may result, with detriment to the child's motivation to learn as much as he otherwise could.

Although it has been proven repeatedly that parents can identify with children of different emotional and racial backgrounds, and with

all sorts of heredities, not every couple of course feels equally accepting of each type of "difference." The agency comes to know applicant-couples during the various stages of preadoptive study, including individual prejudices, fears, and predilections. Accordingly, the child of a schizophrenic parent would not be considered for a couple who has deeply rooted fears about the inheritance of mental illness; a child of interracial background who appears predominantly white is likely to adjust best in a white family. (Several follow-up studies report the success of such adoptions.) He would only be placed with a family, however, who could be told about his background without its creating an emotional barrier.

*What kind and how much information concerning the child's background is given to adoptive parents prior to placement?*

In general, the agency will supply whatever information is available to help the adoptive parents understand the child and his needs, and to enable the agency to answer questions he may later ask about his parents and background. Identifying information, however, is always withheld.

In most instances, the adoptive parents feel satisfied with these details. Occasionally, however, they will continue to feel "uneasy" about the many unknown factors in the child's past. In view of the precautions taken by agencies to evaluate children who are surrendered for placement, those applicants who continue to feel excessively threatened by fears of the unknown, may never feel comfortable enough about adoption and may be advised to withdraw their applications. Some adoptive applicants profess a fear of the child's heredity, which in reality is a screen for other less consciously acceptable fears and doubts they may have about adoption. For instance, persisting fears, despite factual correction, that an infant girl will inherit her unwed mother's "immoral sexual behavior" are not really about heredity at all. In any event, the agency will attempt to ascertain the nature of whatever fears are expressed and to resolve them wherever possible.

As might be expected, the prospective adoptive parents of the older child are provided with rather extensive information concerning the child's experiences in the past, as an aid to understanding him better and to help him overcome the effects of prior emotional hardships. Such information also enables these parents to share, rather than to discourage and wall out whatever memories of his past the older child

clings to as part of his needed sense of self-continuity. Although it is hard for some new parents to acknowledge aspects of their child's life before he became theirs, it makes for greater family closeness in the long run.

Furthermore, if the agency is aware of some genetic defects or assets in a child's background, his prospective adoptive parents are so informed. Also, when adopting a mentally or physically handicapped child, the adoptive parents are advised as fully as possible about the child's handicap and of his prognosis for the future. They are also told when there is a known possibility of racial admixture in a child's background.

***Is it psychologically preferable for brothers and sisters to be placed together or separately?***

As a general rule it is certainly desirable from the children's standpoint emotionally to remain as members of the same family, especially for the sake of those of the sibling group who are beyond early infancy. Such children have already been subjected to the loss of parents or parent substitutes by virtue of their need of adoption, and it is, therefore, all the more important for them to retain their family ties to one another and not have to suffer still further traumatic separation. This causes a difficult placement problem, however, for the agencies, in view of the shortage of homes for more than one adopted child at a time. As in the case of other hard-to-place categories of children, agencies are intensifying their efforts to find appropriate homes and are making headway with several new methods of home-finding. For example, statewide and regional adoption resource exchanges have been established successfully for interagency cooperation in locating suitable homes for children who might not be placed otherwise. The possibility of a national adoption resource exchange is under consideration.

In matters pertaining to human relationships, each situation must be evaluated individually. Thus, although it is usually in the best interests of sibling groups to be placed together, there may be some exceptions. Occasionally, for instance, the relationship between the children is such that one or more can thrive better apart from each other and in different kinds of homes. Similarly, each of twin infants, if still too young to have formed a "twinning" relationship, may have a more advantageous life opportunity from placement with "his own" set of adoptive parents.

*Should the child be told that he is adopted? At what age and how is it best to tell him?*

Adoption experts are agreed that the child should be told of his adoption by his parents. Although many adoptive mothers and fathers find this difficult, fearing to harm the child and their relationship with him, experience shows that the psychic risks are far greater from attempted secrecy. Young children are fortified to absorb from their parents many "facts of life," including adoption, when they feel safe in the sureness of their parents' love and closeness. On the other hand, the shock of learning about his adoption from others, or by coincidence, as is almost bound to happen at some point, can have serious emotional reverberations for a child; his confidence in his parents may be shaken by feeling deceived, and the adoption is likely to be experienced not as an act of love but as a disaster—otherwise why would they have had to conceal it?

Furthermore, at a subtler level, the young child's partial overhearing of mysterious allusions, and his sensing of parental lies, half-truths, and evasions may incur confusion, suspicion, and anxiety for which he needs his parents' help; instead, he feels cut off from them by a conspiracy of silence.

For many parents, the explanation of adoption is complicated, not only by their desire to protect the child's feelings, but their own as well. Much of the discomfort and fear they may experience is closely related to whatever underlying doubts they feel about adoption itself and their own adequacy as parents. To explain adoption to a child means acknowledging one's inability to give birth to him. This may be profoundly threatening for those who could not face and resolve painful conflicts in this area sufficiently, prior to adoption. Sometimes the basis of their strong opposition to telling remains unconscious, and is displaced by overprotecting the child.

Of course there is realistic need to protect the child's sense of security as much as possible by the manner and timing of informing him. It is generally considered advisable to begin telling the child about his adoption as early as he starts to understand language. "Telling" in this sense is a gradual process of communication over a period of time, not a single event. What is told can thus be geared to the growing child's emotional level and stage of comprehension.

The child's normal interests and curiosities at various phases of his development, and the questions children typically ask at such times (as to where babies come from, for instance), will provide parents with an

opportunity to refer to the circumstances of his own birth and his advent into the family.

When parents feel comfortable and sure enough of themselves, they do not need to overdo or underdo on this score. They neither force the topic on the child, inopportunistically, nor discourage his further questions by closing the issue after it has been "dealt with once and for all."

Agencies avoid suggesting any single set formula for how best to tell the child that he is adopted. They realize that the particular wording is far less important than the feelings and attitudes behind it, which somehow always come through. The agency helps primarily in the crucial preplacement tasks of coming to terms with infertility and adoption, but sometimes later as well when these problems are prone to flare up again to some extent as the time of telling approaches.

In addition, the agency workers offer certain overall guidelines about the telling. For instance, psychological drawbacks of "the chosen baby" story are pointed out. If the baby was chosen from among the others, what does he think happened to the "others"? Had he been rejected by other parents who chose someone else instead? Might he be "unchosen" at any time? Above all, the story is untrue. The couple wanted a baby and "chose" how to find him through the agency; they did not shop around choosing from among many children on display. Workers also help prepare couples for meeting the child's questions about his natural parents and why they let him go. In general, once again, the truth seems the best protection against emotional hurt: his natural parents were unable to raise him, for practical reasons; out of their concern for him they asked the agency to select parents for him. As stressed above, telling is a gradual process, with more pieces added on to the same basic explanation in accordance with the child's level of development and focus of interest.

Recently, a few child psychiatrists and child analysts have recommended that the telling of adoption be postponed until the child has reached early elementary school age. This opinion is based on experience in treating some emotionally disturbed adoptive children, as well as on theory of personality development. Other child psychologists, psychiatrists, and analysts, however, whose adoption experience includes the more numerous well-adjusted families as well, evaluate these case reports somewhat differently. When young children are emotionally maladjusted, due to some primary cause such as extremely rejecting adoptive parents, the telling of adoption may well intensify their maladjustment. Although a policy of postponed telling of adoption could

not prevent the basic problems of this minority of troubled children, in their opinion, it could be detrimental to the majority of adoptive families.

For these the possible theoretical gains from delayed telling must be weighed against the harmful consequences. Thus, perhaps it might be advantageous if the child's sense of identity could establish a solid headstart before he is told of his adoption. But preponderant expert opinion considers this more than offset by damaging effects. The child's faith in his parents' reliability is a precious resource for his healthy personality maturation. Postponed telling of adoption jeopardizes that faith. If he chances to find out about it by himself, his confidence certainly suffers. Even if he doesn't, his parents' fear that he might produces tension. Meanwhile, he naturally turns to them for answers to important questions and they feel forced to lie to him. This intensifies the parents' own tension which the child senses with disquiet; it sets up a barrier between parents and child and builds up to his ultimate disillusionment and confusion. For example, if he asks why Mrs. So-and-So looks so big, his mother may use the occasion to explain about babies. But to the next likely question, "Did I grow in your tummy too like that?" she must tell a falsehood, and reverse herself later. It would seem preferable to simplify the truth to fit the young child's age level rather than to distort it.

Of course, special stresses for parents and children are entailed in adoption, and should not be glossed over. It is more complicated for children to unify a sense of self from double parentage; the facts of adoption do lend themselves to certain troubling child reactions, such as self-blame for being "unwanted" by natural mothers, or a sense of apartness from other children. In telling about adoption, parents do worry that the child may no longer love them as fully, or even reject them in favor of his image of his natural parents.

However, a sense of perspective about adoption permits these problems to fall into place in relation to the central reality. Adoption is an affirmative human experience, a giving, not a taking away, a repair of mutual trauma, not a trauma itself (except for unsuitable placements). It is vital that all concerned keep this in view. Adoptive parents, in telling children about their adoption as infants, are essentially revealing what each has gained, not lost. These children have found parents and a family, they have not lost parents they never had, since in all but the biological sense, the men and women who gave them life could not be fathers and mothers. A feeling realization by adoptive parents of this

factually warranted emphasis, and conveying it to the children in their telling, can give more basic reassurance than any set speech.

***Should neighbors, relatives, friends, etc., be told that the child is adopted?***

Quite apart from other considerations, for obvious reasons it would be difficult for adoptive parents to explain the sudden arrival of a child "out of the blue," so to speak. Therefore, extensive efforts to conceal the child's origins could serve no useful purpose. Moreover, there is the added danger that once the child has sensed his adoptive parents' desire to keep his identity a secret, he, too, will begin to feel that adoption is something to be ashamed of.

Changing cultural attitudes toward adoption are investing it with positive connotations. Thus, agency selection of an adoptive couple may be regarded as a socially valued tribute to their qualities as parents. By the same token, the adopted child is no longer pictured as a homeless waif, at the mercy of anyone who will provide him with food and shelter. Rather, he, too, may be recognized as privileged in several ways: his parents were particularly eager to assume the responsibilities of parenthood, and were handpicked by an exacting agency for their child rearing abilities.

For the most part, attempts are no longer made to keep adoption a secret. In fact, the custom of announcing the birth of a baby is extending to adoptive parents who, often nowadays, send out announcements of the arrival of an adopted child. It is generally regarded as advisable that the fact of a child's adoption be known to those in his immediate environment. At the same time, however, this information should not be imparted indiscriminately, or overemphasized, lest it be vested with unwarranted significance.

The adopted child will not, of course, be impervious to the problems and conflicts in his relationships with others that will typically arise at various stages of life. However, his having been adopted need not, per se, make him more vulnerable to such difficulties.

The fact that an individual has been adopted may, at times, be "latched onto," as a screen for various unacceptable feelings that arise in the complex area of human relationships. Children or adults who were adopted share the general range of human failings. Clearly, however, they should be judged on their own merits as human beings, rather than on the basis of life circumstances that were beyond their control.

***Where can adoptive parents go to obtain a child? How much will this cost?***

One of the most distinctive characteristics of adoption, as compared to foster care services, is its permanence. The dynamic feature of permanence may affect the mental health outcome of adoption in opposite ways, depending pivotally on whether the original placement was sound or unsound, psychologically. Clearly, the permanent locking together of lives adds to an unhealthy parent-child relationship and contributes to maladjusted personality development of the child, as well as long-term misery for the whole family. On the other hand, this same factor of permanence is a *sine qua non* for the specific kind of security and continuity that are such potent ingredients for fulfilling the happiness and mental health potentialities of successful adoption. Accordingly, it is of utmost importance that those considering adoption turn to authorized agencies which, statistics show, offer much greater protection against unsuitable placements.

Inquiries as to existent agencies in any particular community or area may be directed to the State Department of Public Welfare through its Child Welfare Division, since this department in most states has responsibility for the licensing, standard setting, and supervision of adoption services by public and voluntary agencies.

Practices vary among agencies with respect to charging of fees for services to adoptive applicants. Ability to pay a fee is definitely not regarded as a proper criterion of applicant acceptability and should in no way affect the choice of the most suitable home for each child. A good many agencies never charge any fee. Others have a sliding scale based on ability to pay in relation to income, or have a set fee with provision for reducing or waiving it when indicated. For couples who can afford it, the payment of a fee enables them to share responsibility for the cost of the agency service and is often welcomed as a kind of equivalent for the medical and hospital expenses of natural childbearing. All agencies are nonprofit, however, and their expenses far exceed whatever may be collected as fees. Independent adoptions, however, may involve heavy expenses; of course, the sky is the limit for black market baby "sales." Furthermore, the many desirable advances in the application of mental health principles in adoptive practice entail increased budgets for adoption agencies (for larger and better trained staffs) to which adoptive applicants can contribute, when feasible, through fees based on costs. On the other hand, a few agencies on rare occasions, have even initially subsidized especially auspicious adoptive



homes for hard-to-place children, when the parents otherwise would have had to postpone adoption until they could afford another dependent.

*On the whole have adoptive placements been successful?*

To date there have been too few thorough and extensive follow-up studies of this important issue although several promising research investigations are currently underway or being planned. Follow-ups have been relatively limited and sporadic in the past, partly because of the general secrecy surrounding adoption. Agencies hesitated to intrude themselves into the lives of adoptive families lest this reminder of adoption interfere with the family's effort to forget its origins and move along in life like "regular" families. Nowadays, with wider public acceptance of adoption there is less connotation of shame and hence less need to deny and hide the fact of adoption. Furthermore, the good relationships established between agency and adopting couples during the adoptive process provide a foundation for future contacts; many adoptive parents accept follow-up inquiries as a sensible way to advance the level of knowledge and thus help others like themselves. Accordingly, conditions now are more propitious for conducting needed wide-scale research. Long-term follow-ups entailing periodic evaluations are important, since certain problems seen at one stage of a child's development may be subsequently resolved, whereas in other instances serious difficulties may only arise or become apparent at later phases.

Nevertheless a good deal of information about adoptive outcomes does exist already, obtained by a variety of methods. There is considerable evidence, for example, that agency placements have a much higher success rate than independent adoptions. Catherine S. Amatruda and Joseph V. Baldwin reported on this in the *Journal of Pediatrics*, 1951. Similar results were found in a larger and still unpublished study that was carried out in Florida. Reports about adoptive results, therefore, that fail to distinguish between these two forms of placement are misleading. Reports from guidance clinics, agencies, and physicians about disturbed adoptive children cannot measure adoptive outcome in general since these sources have but a one-sided view. They do not see the many well-adjusted adoptive families as well, and thus lack access to the total picture. Furthermore, there are no reliable figures as yet, though some have been ventured, for comparing the rates of emotional maladjustment for nonadoptive and adoptive children. On the other hand, individual case studies of emotionally disturbed adoptive chil-

dren, whose disorder may or may not be causally related to adoption per se, are of utmost value in furnishing clues for the continuous improvement of adoptive agency procedures. Many such cases, for instance, have shown the need for better psychological screening and counseling of adoptive parents, and have deepened our understanding of those parental attributes that favor or obstruct successful adoption.

Some agencies provide discussion groups for adoptive parents several years after legal adoption. Although primarily a service, this contact fulfills a follow-up function as well, enabling the agency to check its predictions against the actual life performance of the adoptive families. Similarly, adoptive parents and children can turn to the agency whenever the need arises; not infrequently this occurs during the youngster's adolescence. Again these occasions of helping are also opportunities for follow-up and a chance for the experts to keep learning more about what helps or hinders adoption from those who are actually experiencing it.

In general, a very encouraging overall picture of adoptive success from agency placements emerges from piecing together reported results of the many small-scale and partial follow-ups available, some of which focus on one or another special aspect, such as preadoptive as well as postadoptive intelligence test levels of the children. In one novel study that is underway, adults who had been adopted as children are describing what adoption meant to them.

And finally, for those in a professional position to realize the misery that would otherwise prevail, there is poignant and convincing evidence, day after day, of "successful" adoption: success in surmounting emptiness, terror, and crippling deprivation for three sets of lives; success in meeting human needs and in fulfilling human potentialities.

# ADULTHOOD

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## ***What is adulthood?***

Adulthood is the period of full maturity. Beginning in the late twenties or early thirties, it shades into middle age in the fifties. The mature adult has more than a superficial understanding of himself and of marriage, parenthood, job or career, social and personal responsibility. He has insight, e.g., his conscious life and unconscious life are relatively harmonious. This insight underlies his stability and good judgment, which are basic qualities of maturity. The adult's patterns of feeling and behavior are integrated, allowing purposive behavior for good reasons toward good goals. The challenges of adulthood are the critical challenges of life and it is the adult's responsibility to accept and to work with them. Adulthood is the time of guardianship, of providing for the present and the future, for family, for the community, and for oneself.

## ***How many adults are there in the United States? How many women? How many men?***

In 1960 there were approximately 47 million people in this country between the ages of thirty and forty-nine. Of these, a little more than 23 million were men and just under 24 million were women, a difference of not quite one million.

## ***Do these rates differ from those in other countries? Why?***

With a few exceptions there are more women than men in most Western countries, but the proportion of difference varies almost from country to country. Presumably these statistical differences are the results of the varying effects of World Wars I and II on male populations in these countries.

## ***Are these rates changing? If so, why?***

Present population trends indicate a relative increase in women over men in most countries. This is said to be a direct reflection of the

dramatic decline in female mortality rates in most Western countries. In addition, this age group reflects most directly the number of male deaths in wars since 1920.

*How much influence do the experiences of the early years have on the adult?*

As has been pointed out in the article, *Young Adulthood*, the earlier years greatly influence all succeeding stages of development. If a child is reared in a nutrient emotional atmosphere in which he is supported by love, security, and trust, it is likely that the adult will be a healthy and mature person. Many early influences are disguised or camouflaged by so-called ego defenses that develop as protective mechanisms in response to troublesome or painful emotional experiences early in life. When the adult is subjected to undue stress these defenses break down, as for example, in mental illness or even in anxiety and tension states. Under these conditions components of the personality structure emerge and some of the early influences are thus revealed. But when growth and development proceed in usual fashion, the effects of early experiences are covered over even though, in large measure, they determine the nature of the adult personality. A healthy early life permits the adult to be "the poet of his own emotions," as a wise man has said.

*What are the typical attitudes of the individual approaching adulthood?*

There are surely no attitudes that are entirely typical of the adult population. The following points of view, however, are somewhat widespread:

Most adults are concerned about fulfilling ambitions. They expect a reasonable degree of happiness and satisfaction in the home, the family, and the job, and they expect to work for it.

The healthy adult recognizes the necessity of being in control of himself if he is to arrive at any degree of personal fulfillment. Emancipated from the confining ties of his dependent years, he senses a freedom in his life that is more profound than either the rebellion of adolescence or the independence of early adulthood. At last, perhaps, he understands the distinction between freedom and license. For even the freedom of adulthood is circumscribed by serious and enduring responsibilities to family, to society, and to oneself. If the adult is to enjoy the sanctions of maturity and employ them usefully, he must exercise control over his instinctual impulses. Such control is in a very real

sense the *sine qua non* of true independence. Self-discipline, thoughtfulness, and moderation, therefore, have special significance for the adult if for no other reason than for what might be called enlightened self-interest.

Some individuals take a "now or never" attitude, especially as far as work and money are concerned, feeling that success in these areas during adulthood is the main chance for success in later years. But the traditional materialism of our society is giving way, to some extent at least, to concern about moral values. What is good or useful or responsible to do or to be are common questions for today's adult. He expresses concern for what has other than mere money value. The great religious revival of the twentieth century, the renaissance of interest in art, literature, and music are some examples of this. Perhaps the contrast between the high standard of living at home and the destitution in two-thirds of the rest of the world is stark enough to have stimulated concern about fundamental values among the better educated and socially aware adult population.

In a very basic sense the adult looks upon his time of life as one of industry. He has an activist point of view in business and in community activities and in his general approach to social and political problems.

### *What are the special challenges and stresses of adulthood?*

The challenge of adulthood is in a word the challenge of giving. This is the heart of making a successful marriage; providing an adequate and comfortable home environment; rearing children; achieving satisfaction in the present; and making provision for the future.

Adults must be able to sustain themselves and others in many situations, sometimes in crises in which they have a lonely responsibility. When a member of the family is gravely ill or when there is serious economic reversal, for example, adults are looked to for aid and comfort. In recent years, providing for older folks has become almost as universal a challenge as providing for children. Increased longevity has meant adults are having to deal with the complicated problems of more and more older and older people.

Quite possibly, the typical challenge for adults in our time is conformity without loss of individuality. It is necessary to preserve a certain sense of being oneself while finding a suitable role in society. The leveling and depersonalizing trends in our society add to the complications of this challenge. Individuation as a basic way of life is either disappearing or perhaps is more difficult to achieve and to sustain.

Housing, clothes, reading, entertainment, and especially education have become remarkably uniform throughout our society and are becoming more so. Statutory institutionalization and generalization of human needs has made individuality a cause rather than a characteristic.

The adult faces a constant challenge to his sense of balance, proportion, and relevance in a world in which values are inconsistent and confusing. Relatively few people are fortunate enough to be "doing good" and earning a living at the same time. Selflessness and idealism do not often occur in happy combination with the ordinary sort of work that produces modest rewards, nor even with work that produces unusual rewards. Often the means required to achieve such rewards are not consistent with "doing good" and are explained away in terms of the good such rewards make possible. To deal realistically with value conflicts such as this is a challenge that calls for solid value judgments or else a healthy indifference to social pressures toward "success." It is no mean task to live in a social setting whose values are so paradoxical, yet the adult must learn to do so with a minimum of frustration, and he must work toward desired goals without seriously compromising his own code of ethics or system of values.

Sustaining the marital relationship over many years requires giving of a special and perhaps unaccustomed sort. It requires a mutuality by means of which the relationship as well as the husband and wife may grow. It is important for the father and mother to keep pace with each other in paying attention to the home and family, as well as in developing invigorating interests outside the home. For the husband this means keeping his job or career in focus so that he has time, energy, and above all, feeling left for his wife and children. Men need to make preparation now for later years, aiming at a smooth transition to useful vocational or avocational activity in middle age and beyond. Women need to expand their world beyond the limits of household chores and cares. Adult education courses, habitual reading, volunteer hospital work, hobbies, even if only on a limited basis, can refresh her emotionally and intellectually. These are important as against the time when she is no longer on duty twenty-four hours a day. They are especially important during the years when children must be her preempting concern, but not necessarily her exclusive preoccupation. Those years are relatively few and pass quickly. To some extent, vicarious living out of children's experiences is healthy. But more is needed. Mother needs an opportunity for personal satisfaction, for expressing her individuality.

She must avoid oversolicitude of her children, just as when they become adults, she should avoid overdependence on them. Under this condition she becomes an unpleasant and unwelcome burden on her children, losing their respect as well as her self-respect in middle age, when she can least afford to do either. Both parents should be growth-inducing models for their children, and should rear their children to learn gradually to do without them. Home should be the place from which children can depart healthily.

The monotony of routine is a real difficulty for adults, and possibly becomes more so as the world outside the immediate environs of home and job becomes more and more accessible. Many adults develop a sense of the immutability of the tasks of earning a living and running the home. This situation challenges both the adult man and woman to develop genuine interest in work or what it provides, and to find satisfaction in the fascinating process of children's growth and development. Yet it is a further challenge to recognize the limits of satisfactions in these activities and to turn to stimulating interests outside of job and home. These can mitigate, to some extent at least, the tedium of endlessly repeated ordinary tasks which in and of themselves offer no special challenge and which are soon exhausted of their potential for generating and sustaining motivation.

The marital relationship may be challenged by unanticipated and quite impulsive emotional attachments to third parties. This can happen for men and for women. Such transitory involvements can occur to almost anyone at almost anytime without malice or forethought, and despite a marital relationship that appears to be quite satisfactory. The decade of the forties seems to be an especially vulnerable time in this respect. Understanding and support can play a critical role here in preserving a relationship that has, after all, lasted for a good while, and given an opportunity, will undoubtedly go on for many years. The people involved in such impulsive interludes should guard against overreaction. Patience, good humor, honest expression of feeling, and above all, full and open communication will almost surely reestablish the strength of the marital relationship.

Advancing years bring rigidity in attitudes and behavior. It is a challenge for the adult to remain receptive to new ideas, accepting of differences, and flexible in reaction and behavior. Indeed, the daily existence of every adult brings such a variety of problems and challenges that flexibility becomes a prime requirement.

*Are these challenges and stresses different today from those in the past? Are they in the process of change? Why?*

The challenge is probably not different in kind, but almost certainly it is different in degree. There is a generalized high pressure quality to modern life. In part this results from an obsession with technology, excessive competition, and "success" orientation. In part it results from the tensions of an upset world in which rapid changes and abrupt transitions at all levels and areas of society are commonplaces. Singly and in combination these factors make for what must be an especially challenging and stressful existence compared to almost any past era. Adults must meet and deal with these social changes, not as historical phenomena, but in the ordinary work of everyday routine.

The social and psychological pressures that have shaken the home and family life have created more problems for adults and intensified the old ones. Whereas in an earlier time—the turn of the century for marked contrast—the home was a central authoritarian force for growth and stability, in too many instances today it is a flaccid and somewhat undefined influence. Children may often depend upon parents until well into their twenties. This extended period of dependence is in itself a new phenomenon. It has emphasized the usual difficulty for parents to maintain an appropriate influence over their adolescent and young adult offspring without interfering unduly in their lives. Protracted dependence also exaggerates a complicated task parents have always had, that of playing various roles as their children grow and develop.

The challenge of preserving individuality has become increasingly difficult in the face of population pressures and the resulting institutions, mechanisms, and devices for dealing with people en masse. Maintaining a sense of one's own worth is made even more troublesome by the compromises adults feel called upon to make in order to achieve higher and higher standards of living in a society where overcompetitiveness is characteristic.

As models for the younger generation, adults have a profound challenge in the area of values. The world around us is unstable and in some critical respects, unpredictable. As always the younger generation gains support and achieves maturity in large measure by emulating adults. Probably there have been few times in history before this, when a need for a solid philosophy of life and for composure in the face of a stressful and uncertain existence has been more acute. Thus it is an especially poignant task that adults have in representing a prototype of



point of view and of behavior with which young people can healthily identify themselves.

The problem of leisure time is a new and pressing challenge for almost every adult. It is a somewhat paradoxical one. For it is possible to work very hard, and longer than the standard eight-hour workday of the recent past, thereby achieving a great deal more particularly in financial terms. It is also possible to maintain a usual standard of living by working fewer hours per week. This raises the problem of what to do with the time one does not spend at work. It requires serious thought and planning, and a vast educational program in order that adults may be taught the constructive uses of free time. It is perhaps more important that they should be educated to attitudes that are appropriate in a life that requires fewer and fewer hours of work in order to provide the essentials of existence.

*How are these challenges and stresses usually met by the adult?*

The problems adults face are variable and individual, and are therefore not susceptible to easy or pat remedies. Solutions to problems are derived from general personality assets and situational resources and their limitations.

Most adults in our society are realists in their work and family relationships, idealistic in their philosophy, and occasionally impulsive in their social behavior. But they are pragmatists in their approach to problems. They meet most challenges by taking action. The mature adult is decisive. This means that after some thought and planning, he defines his problems and assesses their risks. Then he acts. The ability to make decisions, the exercise of good judgment toward attaining reasonable solutions to problems is highly valued. A common point of view is that a decision is in and of itself important. Even though at times the immediate cost may be great, indecision and procrastination exact a heavier toll. "Think it out and work it through" could well be an appropriate slogan. Adults accept responsibility for their decisions, recognizing that few decisions have irrevocable consequences. Changes of mind are often desirable and sometimes necessary. Again the matter of good judgment is relevant in minimizing vacillation as well as rigidity, indecision as well as stubbornness.

In spite of all that has been written and said about our overemphasis on money, many adults still think that if they had enough money most of their problems would be solved. Of course money does solve some problems and is a great aid in others; but parents are too often deluded

into using money as a solution to problems arising within family relationships that really require something very different: emotional maturity. Bribing children with gifts often substitutes, but poorly, for disciplining them and loving them appropriately. Many fathers excuse their frequent and extended absences from home "on account of business" as being necessary for adequate family support. In parent-child relationships material welfare, however generously provided, is not sufficient, and if unduly stressed may be deleterious to the family's emotional security. Father's presence should be more important and more constructive than father's money. But it isn't just a matter of spending time with children. Adequate emotional support depends upon the quality and value of the experience parents create for their children rather than merely the amount of time they are together. In the long run, adequate emotional support is more difficult to provide than material well-being, but is more valued by children.

*What are the essential characteristics of this period?*

Responsibility is the essential characteristic of adulthood; i.e., responsibility augmented by good judgment and adequate insight. The tentative commitments of early adulthood in social and emotional relationships and in careers are now organized into more or less regular patterns of action. These make for stabilization and dependability. Adults have the responsibility for protecting, nourishing, and educating the family; they are the hard core of the economic, social, and political life of society. The emotional satisfactions of parenthood, as well as the dissatisfactions and disappointments, are characteristic during this time of life.

Father's motivation is to succeed in his work and to improve his family's lot. He is responsive to family needs and desires and encouraged by their respect for his efforts. Similarly, mother derives support from the emotional atmosphere in the home and from her day to day relationships with her children. Both mother and father share an increasing depth of understanding in their relationship with each other. They become increasingly interdependent, from which each gains added individual strength.

The period is characterized by a sense of security which is the forerunner of an even deeper serenity of later years. Fulfillment of male and female roles comes with marriage and parenthood especially. Compromise and flexibility rather than rigidity and inconsistency should basically characterize the adult.

***How do these characteristics differ in certain economic groups? Intelligence groups? Religious groups? Urban vs. rural groups?***

Economic pressures can deflect too much thought, attention, and feeling from family life, unduly hampering expressive and flexible interpersonal relationships within it. Financial difficulties may make critical trouble between husband and wife at any socioeconomic level, perhaps especially so in families with very low incomes. But this is also a danger in middle-class suburban families for whom social status is determined by a particular standard of living. Excessive concern about special styles of dress, models of automobiles, membership in clubs, etc., distinguish such groups. In recent times, the blandishments of an affluent society have put difficult pressures on families in the middle classes. This is especially true in those families in which ambition for social and economic improvement is not kept within reasonable bounds by the maturity of the parents. Emotionally mature parents, even at low socioeconomic levels, can structure family life so that financial burdens become a catalyst for mutual understanding and support. Religion or any honest ethical conviction that encourages respect for family relationships gives special stability to family life. But parents who place undue emphasis on what used to be called "the sanctity of the home," do not thereby guarantee a good family life. Rather, parents who define and explain basic ethical concepts and then encourage reasonable flexibility in values and standards are often able to lead their children into a healthy balance of dependent and independent behavior, without, on the one hand, uncomfortably straining family ties, or on the other, inhibiting individuality.

In families with above average intellectual capacity there may be profound understanding of the forces at work in family relationships. More important than this, however, is the presence of emotional rapport among father, mother, and the children. This may occur at any intellectual, social, or economic level. When it does, there are usually realistic expectations within the family, combined with an active sense of mutual responsibility and a lively give-and-take in daily living. Oppositely, families of high intellectual capacity may use their intelligence to limit spontaneous expression of feelings. This results in a cool emotional atmosphere in which formalism replaces spontaneity, and immaturity, insecurity, and defensiveness may be characteristic.

There are probably very few significant differences in these characteristics in urban versus rural groups. By and large, society is so mobile, and communications are so effective that social life does not vary in

fundamental ways from city to rural areas any more in the United States. Such differences as exist are probably oriented around religious affiliation and family occupation, particularly in areas where agriculture, mining, and textile manufacturing or other regionally determined industry is the predominant source of income and where, therefore, the entire family may be involved in producing the family income. Stringent family obligations of a kind that used to differentiate country life from city life have all but faded from the scene. Young people are turning more and more to the educational and career opportunities of urban centers and adults do not need to spend nearly as much time or energy in earning a living as they once did. Thus, the economic and social pressures, even the religious ones in many instances, that once made the family unit so cohesive, especially in rural areas, have greatly diminished. Indeed, the problem of leisure time for adults, even at the peak of their responsibilities and obligations and at the height of their earning power, is becoming a characteristic problem at all levels of society.

***What are the reasons for the differences in attitude between the male and the female adult?***

There are undoubtedly innumerable reasons that would account for differences in attitude between male and female adults. The social and economic realms seem to be fertile sources for some of these differences. Adult men and women are surrounded by persuasive evidence that sufficient effort will be rewarded by a high standard of living for the family and advantageous opportunities for children, especially in education. But the question of what is to be valued and what values are to be transmitted to the children may be the real source of difference of attitude between mother and father. This is especially true in families where father is preoccupied with earning a living at the cost of spending insufficient time with his wife and children, while mother finds the routine of running the home and carrying out the endlessly repetitious tasks, which are necessary to family life, increasingly tedious. Yet the more successful father is in business, the more possible it becomes economically, at least, to free mother from these chores, and the more time mother has to spend in the world outside her home. As a result, mother and father are too often going in separate directions, making different value judgments and holding out conflicting goals for their children.

Contrary to past experience, the virtue of money and economic

stability are values children now seem to learn from mother whereas the virtues of education, the arts, and a liberal point of view may well be inculcated by father.

Another source of difference may arise from the fact that father must recognize that in liberating mother from the drudgery of household routine, he makes it possible for her to develop her own outside interests. Some of these may augment father's interests while others may conflict with them. This freedom and broadened experience makes mother more capable of influencing children's lives beyond the home in ways that were once almost entirely father's prerogative. Father will, therefore, need to develop quite flexible attitudes and a profound sense of security so that he can understand and accept this changed role of women, rather than be unduly threatened by it. Indeed, fathers should find comfort and support in the fact that mothers can play such a broadened role in their children's lives, for this means a richer life for everyone in the family, including father.

Other sources of difference may be seen in the very active role women now play in political life, in the economy, and in society generally. Women now may be, and often are, as individualistic and aggressive in their ideas, in their affiliations, and in their activities as they were once thought to be quiet, passive, and uninterested.

*What intellectual, social, or emotional changes usually take place during adulthood?*

The classic change that occurs during adulthood is the replacement of the liberalism, permissiveness, the anti-authoritarianism of youth by conservatism, regulation, and concern for authority. "Who is not radical when he is young lacks heart; who is not conservative when old lacks head." However, this change from radicalism to conservatism is no longer as clear as it once appeared to be. Widespread education, ease of social mobility generally, and exposure to all the information and experiences that modern technology makes possible, have encouraged many adults to sustain their youthful sense of adventure and to indulge their curiosity in the novel and the untried, postponing for at least another decade the time when they will "settle down" in anything like the old-fashioned, somewhat limiting ways. Indeed, it is a phenomenon of our times that a reversal of the classic pattern is almost the case. Namely, there is a growing conservatism among youth and a stronghold of liberalism in the adult population. Among other reasons for this is the security provided by the high standard of living

we now enjoy. This has freed many adults from the heretofore confining necessities of earning a living at the level of mere existence, while adolescents and young adults have yet to arrive at such affluence and, in face of all the social and psychological pressures toward success, feel they can ill afford to take the risks they once accepted almost without pause.

Nevertheless, it is still true in general that the sense of commitment, obligation, and responsibility that comes with adulthood, together with the impetus and opportunity to produce and to earn, persuades most adults to place a high, perhaps excessive, value on material security as well as the achievement of a respectable place in the community. The status quo becomes important whereas in earlier years it was a target of attack. New ideas and new experiences are welcomed a bit less readily than they once were. There is a gradual "settling in" process and a parallel diminishing in risk-taking. Flexibility and the capacity to accept change, even to welcome it and to make appropriate compromises, give way to clinging to the familiar, to resentment of change, and needless rigidity.

***How much influence do the experiences of the adult have on the rest of his life?***

The kind and quality of emotional investment one makes during these years determines in large measure the degree to which one moves comfortably and securely into the less active period of his middle age. It is perfectly clear, for example, that if one were able to make sound financial investments during adult life, one would be able to provide a comfortable situation for later years. Most people can understand this and many try to do something about it in terms of insurance, savings, or pension funds of one kind or another. The same is true in the emotional realm. Sound investments of time and thought, effort and feeling in family and friends, in social activities and institutions during adulthood, can make a critical difference to mental health in later years. An emotionally satisfying life in adulthood makes for considerable easing of needs later on, with less dependence on others and less anxiety about the inevitable separations and insecurities that come with advancing years. This is especially important for women who will need various compensations when children move away from the home and mother, toward their own independent lives. Mother must be prepared to find satisfying and useful things to do with the time and energies she once lavished so freely on household chores and her children. In other words,

it is important for adults to plan for their retirement while the many resources and opportunities of their adult lives are available, in order that retirement does not mean resignation.

*To whom can the adult turn for guidance and help in his own environment?*

It is unfortunately still true that many adults consider it a sign of weakness to ask for help with personal problems and an undesirable stigma to accept it. Yet anyone may be in need of such help at some time or other in his life. Help may be especially efficacious in adulthood when responsibilities often are in conflict and become burdensome. To recognize the limitations of one's capacities, to deal with problems, and to seek appropriate help when those limits are exceeded is a mark of maturity, a sign of strength not of weakness, of health not of sickness. Thus members of the family, close friends, professional or business colleagues, clergymen, or family physicians are all appropriate people from whom to seek guidance, provided one has a sense of trust in these relationships. In circumstances of profound trouble, professional help should be sought from psychiatrists, psychologists, social workers, or other persons qualified by training and experience to help with such difficulties.

*What are the agencies or institutions in the community that are specifically concerned with the problems of the adult? What is their function?*

These vary from community to community. In very sparsely populated rural communities psychiatric facilities are still difficult to come by. There are only about 1400 psychiatric clinics in the entire United States. Half of these give only part-time service and half are located in the northeastern part of the nation, close-by only one-fourth of the population. The best estimates suggest that there should be one clinic for every 50,000 people or 3600 full-time clinics in this country. In other words, we are short by about 2200 clinics of any kind and the discrepancy is even greater if one counts only the full-time clinics presently in operation. The National Committee Against Mental Illness, Incorporated, estimates that we lack 80 per cent of the full-time clinics we need. Even under such limiting conditions most communities have available to them, however remote and minimal, some professional service for at least the most serious mental illnesses. Such facilities in-

clude private psychiatric consultation, psychiatric clinics in private and public institutions, traveling psychiatric clinics sponsored by state and other mental health groups, and private and public psychiatric hospitals. In addition, there is a variety of specialized clinics, none of them numerous, under the jurisdiction or sponsorship of educational, religious, fraternal, and government organizations. Among the latter is the National Institute of Mental Health of the United States Department of Health, Education, and Welfare. This lends impetus, prestige, and moral support to the entire psychiatric community throughout the country, as well as providing financial support to a very large segment of it, for both research and service activities. In addition, the National Institute of Mental Health carries on extensive research and treatment programs. Among other needs is that for combined inpatient and outpatient psychiatric programs. These provide hospital care for adults in acute emotional crises. As soon as feasible they are returned to community and family responsibilities, while maintained on rehabilitation and treatment programs. Follow-up may continue for extended periods of time if necessary. An example of this are the so-called halfway houses that are presently being established in some metropolitan communities. These provide an interim situation between hospital and private life while patients continue on a supervised therapeutic regimen.

There is need everywhere for more information about the emotional difficulties of adults and their prevention, as well as facts about maintenance of mental health. The problems of research into mental illness are still formidable, though increasing attention is being paid to psychiatric research. Much of this is under the aegis of the National Institute of Mental Health, but there are many research projects in hospitals and universities throughout the country. The problems at a minimum are many and complicated and not likely to yield readily. They require the kind of research and industry once applied to bacteriological disease.

Many states are finding that one of the largest items on their annual budgets is the sum of money assigned to the care, treatment, and management of persons with emotional disturbances. This is one measure, at least, of the dimension of the problem and also an indication to every adult of the importance of becoming aware of and interested in mental health problems in his own community. Because many adults are so concerned, there is an increasing ground swell of pressure in the adult population for more adequate facilities for preventive mental



health measures, as well as for better care of those who have frank emotional disturbances.

*How are mental disorders treated in the adult?*

Psychotherapy, in any of its forms whether intensive or prolonged, as in the case of psychoanalysis, or any other "talking-out" process, has been very helpful to most adults, though it is perfectly clear that psychotherapeutic techniques need to be further refined and psychiatric skills need to be further sharpened. In addition, drug therapy, particularly the tranquilizers, have been useful in ameliorating distressing symptoms such as severe tension, anxiety, or extremes of mood, and thus effective in helping disturbed persons become more amenable to psychotherapy. While not cures themselves, these drugs are often helpful in making people more amenable to psychotherapy, which, can be curative.

The most frequent emotional disturbances seen in the adult group are anxiety states and alterations of mood, especially depressions of varying degrees of severity and duration. Schizophrenia is also a common illness among adults. Many of the four million alcoholics in this country are in this age group. Undoubtedly a vast number of adults suffer from psychoneurotic and personality problems, though the statistics show that only a small percentage of them require hospitalization. The adult population represents the greatest number of first hospitalizations for serious mental illness in the entire population. These problems are detected usually when adults are unable to continue carrying on their responsibilities either at work or in the home. Industrial or family physicians are consulted for intense feelings of sadness, inability to concentrate, insomnia, apprehension, fatigue, strange and disturbing thoughts, and a wide variety of symptoms which disrupt their usual activities. The more serious problems may be detected by the bizarre, strange behavior of the person so afflicted. In such situations, family doctors refer the individuals for psychiatric consultation and treatment. When hospitalization is indicated the family physician may accomplish this himself or may call upon community resources to help affect hospitalization. Only the minority of adults with emotional disturbances are treated as inpatients in hospitals. By far the majority of them are in outpatient treatment with private psychiatrists or in clinics. As has already been indicated, the facilities are inadequate in number and in some places inadequate in quality. It is clear that in recent years lively public interest and vigorous government

action have gone a long way toward cleaning up substandard conditions, especially in overcrowded state hospitals, and toward providing more psychiatric facilities.

*What is the rate of success of treating mental disorders in adults?*

This has been constantly improving. In particular there has been a significant rise in the rate of cures for inpatients in mental hospitals over the past half century. Hospitals such as the Massachusetts Mental Health Center in Boston, the Menninger Foundation Hospital in Topeka, Kansas, the New York Hospital (Westchester Division, White Plains, New York), and even many state hospitals have reported significant advances in the treatment of emotional conditions which afflict the adult population. In some instances hospitals have reported that as many as 80 per cent of their patients have been discharged as improved or recovered within the first year. It is a little more difficult to establish the rate of success in treating mental disorders in adults who are treated as outpatients, because the statistical reporting in this area is quite inadequate. But there is an extraordinary demand by the adult population for access to available facilities and the increasing acceptance of psychiatric treatment can be measured in terms of referral from educational, industrial, and government institutions. This suggests very strongly that psychiatric treatment is effective and becoming more so. In this connection it is important to remember that the vast majority of adults with emotional problems suffer from transient symptomatic reactions that are more or less readily ameliorated.

*Are the methods of treatment likely to undergo any change in the near future?*

Very likely. Every first-class psychiatric institution is heavily engaged in research directed toward improving treatment methods. More and more physicians are specializing in psychiatry, and appropriations in federal and state budgets for the overall mental health needs of the population are increasing. In particular, funds assigned for research in this area, though still inadequate, are nevertheless identified as appropriate expenditures and there is a noticeable increase of government and privately supported effort in this area. At the present time less than half of the recommended percentage of individual state mental health budgets are being devoted to research. But here too there is increasing response to this obvious need. Research in all areas of treatment modalities is definitely on the upswing, and it is safe to say that

this expanded effort will be reflected in improvements in the treatment of these diseases. The impact of tranquilizers on this whole field and the result of vast research is the most recent and most impressive example of this kind of change.

***Based on current studies what might be predicted about the general mental health of adults in the near future?***

The combination of fruitful research and widespread mental health education in schools, churches, industries, government, and in the population generally, should lead to substantial gains in the overall mental health of the adult population. Mass communications media as integral devices in mental health programs, only recently put to use, should make an enormous impact in this area. At present, the ultimate effects of this can only be surmised. Individuals are becoming alert to the role of emotions in everyday life. They are becoming more knowledgeable about their own feelings and the effects of feelings upon day-to-day performance. Parents and teachers alike have become aware of emotional influences on children. There is an unmistakable ferment about emotional problems in this country and a clear public concern to take action about them. In this situation it is reasonable to expect that there will be significant improvements in the mental health of succeeding generations of adults.

# THE ADULT MALE

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## ***Does the adult male have special mental health problems?***

Yes. Most men are subject to stresses and strains that women and children generally are not. Pressures on women and children may be just as great, but they are different. The symptomatic results will therefore differ.

Sigmund Freud pointed out that civilization itself creates "discontents" and contributes to neurosis. The more domesticated and civilized (including urbanized) man is, the more he must regulate his primitive sexuality and aggressivity and in most cultures, the more he must give up the gratifications of childhood dependency. The passing of the patriarchal family, for example, imposes greater burdens of self-reliance on the smaller, individual family units.

The social role of the male, in the American culture, is such that masculinity and even virtue are especially equated with success, notably professional or business success. Men particularly, therefore, are expected to give up passivity, dependency, and even sexuality in order to succeed. Aggressivity may be expressed in intense competitiveness, but excesses must be curbed. As Margaret Mead pointed out in *And Keep Your Powder Dry!*, in America we are ambivalent about masculine aggression. Men's goals, therefore, are hard, the risks are great, and the failures are numerous. Granting significant cultural and social status differences, it must be said that men are especially vulnerable to mental health problems. These problems, however, are not necessarily severe; they do not bring a disproportionate number of men to psychiatrists or to mental hospitals. Rather, they express themselves in "tension" symptoms, in vague physical complaints, and at times in psychosomatic illnesses.

## ***What is the nature of the adult male's mental health problems?***

The answer varies markedly with the observer. Men, according to a report of the Joint Commission on Mental Illness and Health entitled *Americans View Their Mental Health*, regard themselves as reasonably well-off. Men describe themselves as less worried, happier in marriage,

more secure as parents, and less likely to feel that they have ever had a "nervous breakdown" than women in describing themselves. As the report points out, however, men are probably less ready to admit or to discuss problems.

The psychiatrist has learned to expect mental health problems at every developmental stage—from weaning to senility—and with every major adaptive effort. For the adult male, these typically include leaving the parental home, serving in the armed forces, marrying, becoming a father, getting ahead in business or other vocation, growing older, and retiring. Less typical are crises of sickness, disability, unemployment, transfer to new communities, and acute family problems. The majority of men cope successfully with life's vicissitudes; some break down. In between, there are a considerable number who develop anxiety, psychosomatic distress, or "tension symptoms" in the course of their adaptive efforts. Whether treated or not, these are mental health problems.

Anthropologists, sociologists, and psychiatrists alike take note of the impact of cutthroat competition in our culture. The psychiatrist is especially aware of how the exhausting striving for success comes sharply into conflict with unconscious wishes for relaxation, security, and love—the derivatives of dependency and of parental love and protection. Numerous tension symptoms, neurotic reactions, and psychosomatic illnesses arise from such conflicts. The patients of a psychoanalyst highlight the universal problems of our culture. Franz Alexander describes them in his book, *Our Age of Unreason*:

The analyst sees his patients—physicians, lawyers, engineers, bankers, advertising men, teachers and laboratory research men of universities, students, and clerks—engaged in a Marathon race, their eager faces distorted by strain, their eyes focused not upon their goal, but upon each other with a mixture of hate, envy, and admiration. Panting and perspiring, they run and never arrive. They would all like to stop but dare not as long as the others are running. What makes them run so frantically, as though they were driven by the threatening swish of an invisible whip wielded by an invisible slave driver? The driver and the whip they carry in their own minds. If one of them finally stops and begins leisurely to whistle a tune or watch a passing cloud or picks up a stone and with childish curiosity turns it around in his hand, they all look upon him at first with astonishment and then with contempt and disgust. They call him names, a dreamer or a parasite, a theoretician or a schizophrenic, and above all, an effeminate. They not only do not understand him—they not only despise him, but "they hate him

as their own sin." All of them would like to stop—ask each other questions, sit down and chat about futilities—they all would like to belong to each other because they all feel desperately alone, chasing on in a never-ending chase. They do not dare to stop until the rest stop lest they lose their self-respect, because they know only one value—that of running—running for its own sake.

*What are the mental health problems of the young adult male?*

First, let us divide adult males into young, middle-aged, and aged. The young adult male is a man between the ages of twenty-one and forty. Or he is a man who has left his parental home and who, if he has children, still has them of school age and in his home. The middle-aged man is, roughly, between forty and sixty-five. His children are grown up, or nearly so, and may have married and left home, but he has not yet retired. The elderly man is over sixty-five and usually retired. (See *The Aging and the Aged*)

Typical adaptations required of the young man include those of military service, economic independence, marriage, fatherhood, and vocational achievement. Less frequently, adjustment to sickness, injury, unemployment or to the loss of a wife or a child is required. The ideal of masculinity in the American culture requires that the adult male "act like a man" in all of these situations and crises. He is expected to be "stronger" and "better controlled" than women are. Any real or apparent failure to live up to this masculine ideal—for example, inability to support a wife and children—invites loss of self-esteem, feelings of guilt or shame, and even depression. It is therefore harder for a man to be sick, injured, unemployed, or in any way "inadequate" than it is for a woman or a child, and therefore more productive of symptoms of emotional stress and conflict.

A major problem for most young men is how to be a good father. The "good father" is at cross-purposes in our culture. On the one hand, he must be successful, and this usually means being away from home during most of his children's waking hours five or even six days a week. On the other hand, he must be a good example for his children, a good leader, a good disciplinarian, a good friend, and a good companion. For the sake of his children, indeed, he should be a good husband to his wife, because a happy wife is a better mother, other things being equal, than an unhappy one. The task of balancing out the physical, social, and emotional needs of all members of a family is by no means an easy one, and the pressures on a young father are telling even though it often ap-

pears that he can "pass the buck" to his wife. When the father comes home after a hard day at the office and greets the mother who has had a hard day with the children at home, and when both want to "let down" at the same time, life can become very difficult.

*What are the mental health problems of the middle-aged male?*

One of the most common problems of middle age, of course, is accepting the fact of middle age. Many men are consciously or unconsciously so threatened by the notion of growing older that they try to ignore this reality as long as possible. Jokes about the "dangerous forties" express the problem and often are not so funny when men constantly have to prove that they are "just as young as they ever were."

Middle-aged denial of aging takes many forms. The man who contents himself with buying brilliant pajamas is perhaps being merely a source of innocent merriment, but when he is driven to an affair with a woman half his age, he can make life very complicated for himself and at times for numerous others. Such affairs may, of course, be very gratifying; but they may equally well be very pathetic or, in the long run, disruptive. It is only being realistic to observe that middle-aged affairs and remarriages are frequently attempts to deny the fact of aging and are seldom as successful as anticipated.

The man who must go on proving his physical prowess is also a familiar figure. When middle age recognizes its limitations the result is generally good; otherwise the result may be a "coronary," or some other reminder to behave. Doctors have remarked that an early coronary is good insurance because of the enforced moderation it imposes. This "mot" is also a commentary on a breed of men who require such a policeman.

More subtle expressions of conflicts about growing older are sometimes seen in difficulties in allowing one's children to grow up. A man may unconsciously wish to dominate his son in order to deny the fact that both are older, to maintain his own sense of adequacy, and at the same time to hold onto a beloved companion. The problem with a daughter can be similar, particularly if the man has excessive needs for proof of love and admiration from younger, more attractive women than his wife. It is always something of a wrench when a son or daughter goes off to college, marries, or leaves home for a career; the separation feelings become a mental health problem only if they take the form of panic or marked depression or when continued efforts are made to prevent the inevitable emancipation. How hard it is to allow chil-

dren to be children when they are young, and then to be adults when they are grown up.

*Does the pace of modern living—being an effective husband and father, earning a living, commuting, doing community work, studying and striving for self-improvement, being a part-time athlete, gardening and repairing around the house, etc.—make men more vulnerable to mental disorders today as opposed to thirty or forty years ago?*

This question speaks particularly for tens of thousands of men who live in large cities or their suburbs. It is less relevant for farmers, ranchers, citrus growers, or small-town business or professional men whose homes are no more than fifteen minutes from their offices or twenty minutes from the country club. The latter group represents men of thirty or forty years ago, at least as to their mode of life. In other respects, however, a report of the Joint Commission on Mental Illness and Health tells us that age is more significant than geography: "A young, educated, male farmer is more like a young, educated, male New Yorker than either of these people is like his own father."

The fact that men have changed so much in one generation represents one difficulty in answering the question. There really are no reliable statistics about the incidence of mental disorders, either at present or as contrasted with the past. The proportion of patients in mental hospitals, for example, was about the same in 1940 as in 1957, but was higher during most of the intervening years, with 1945 as the peak. Community surveys in recent years give an incidence of mental illness in the population at large varying from 4 per cent to 33 per cent. In other words, we simply do not know; and the same is true for the changes from forty years ago to now. The pace of modern life certainly produces its symptoms of stress, but the human organism has vast capacities for accommodating to stress. It is, therefore, a moot question as to whether men are now more vulnerable to mental disorders than before.

*What are some of the difficulties in estimating the mental health problems of the adult male?*

The reluctance of men to talk about their emotional problems has already been mentioned. Men are likely to feel that neurotic difficulties are a female luxury. At the same time, however, there is a greater awareness of such problems than in the past and a much wider spectrum of conditions classified as mental or emotional disorders. Factors



of changing awareness, acknowledgment, case-finding, and definition of terms all contribute to the difficulties of measuring the prevalence of mental illness.

Karl Menninger once remarked that he wondered why all farmers are not psychotic. They live in perpetual uncertainty. If it rains, it may rain too little or it may wash out the crop. When the sun comes out, it may shine for only a few hours or for burning, blistering weeks. Some farmers do indeed become psychotic, but the vast majority do not. They adapt to the wantonness of nature, often by character traits of stoicism, resignation or, not infrequently, religious faith. Grant Wood's "American Gothic" mirrors the farmer's adaptation to the rigors of his life. The hard-driving New Yorker with his ulcers is likewise "adjusting" in his way; and so in a sense are members of the Dexedrine-Seconal set. Diagnosticians disagree as to who is sick and who is well, and as to whether society itself ought perhaps be the patient.

Reactions to stress of whatever nature are the product of so many variables in the individual and in the environment that it is extremely difficult to isolate them. The psychosomatic problems of World War I, for example, were predominantly cardiac: "effort syndrome," "disordered action of the heart," and so on. In World War II, by contrast, gastrointestinal syndromes predominated. Roy R. Grinker and John P. Spiegel have suggested in their book, *Men Under Stress*, that the difference may lie in whether the outlets for mobilized aggression are relatively few (as in the static trench warfare of earlier days) or many (as in the active, mobile warfare of tanks, planes, and commando units). There have been changes in the outward manifestations of mental disorder in civilian life as well. Today psychiatrists seldom see the "classical neuroses" described by Jean Martin Charcot, Freud, and others before 1900, and this is due partly to refinements in diagnosis and partly to actual changes in the symptomatology of neurotic disturbances.

Freud's assumption that civilization is achieved through successful repression and control of infantile, sexual, aggressive, and dependency strivings requires that we consider not only the frustration of these drives in a predominantly urban society, but also the forces that hold these primitive impulses in check. Historically, authoritarian governments, religions, and family structures exerted such controls. To the extent that these institutions are less influential in matters of personal conduct, the individual himself has greater responsibility for regulating the expression of his impulses. To be able to do so is part of the democratic, individualistic, and humanistic ideal, but it does make more dif-

ficult the task of adult living. It is this relaxation or dissipation of external controls over individual destiny as much as the pace of modern life that, according to some authorities, makes for our present difficulties—to the extent that these difficulties may be different, and possibly more prevalent, than in the past. To the moralist this is the modern form of *hubris*, man's assumption of godlike authority; and, according to the Greeks, whom the gods would destroy they first make mad.

*Does the pressure of competition in business and the professions cause even successful men to break down physically or mentally, or to die prematurely?*

Probably not, but there is little proof. Most men thrive on competition; relatively few are destroyed by it. In any case it is necessary to consider several variables, including the "personal equation."

A 1930 study, cited in *Life Insurance and Medicine* by Harry E. Ungerleider and Richard S. Gubner, indicates that the death rate for professional men is the second lowest of any major occupational group, agricultural workers being lower. The third lowest rate is shared by proprietors, managers, officials, clerks, and kindred workers. Unskilled workers have the highest death rate, with semi-skilled workers next. A comparable British study, which also included wives, revealed similar results, and suggested that the environment—nutrition, living conditions, and so on—may be as important as the occupation.

If successful men are judged by their incomes, they are doubly well-off, according to the report of the Joint Commission on Mental Illness and Health, *Americans View Their Mental Health*. The report states that high income is associated with greater happiness, fewer worries, more frequent anticipation of future happiness, and fewer physical symptoms, but more symptoms of energy immobilization (gauged by moist palms and difficulty in "getting going" in the morning). The middle income groups are generally worried about money but otherwise least anxious and most optimistic about the future. Persons of low income are likely to be unhappy and worried, lacking confidence in the future, and are disposed to physical symptoms. Here again, environmental factors may be important.

Many psychiatrists hold that no one has a "nervous breakdown" from overwork. If a man drives himself beyond his capacities, the fault lies in some neurotic compulsion to exceed himself. Granted that the American culture rewards "success" and affords ample opportunity for destructive competitiveness, the fact remains that most business and pro-

fessional men compete successfully and set their sights according to their abilities.

Some men are "wrecked by success" rather than by pressure of competition that makes for success. Such breakdowns occur for a number of reasons, including the fact that the unconscious meaning of success may be the destruction of one's earliest rivals—for example, parents or siblings. Conflicts engendered by rival claims of home and career or of "masculine" and dependency strivings, for example, may also make for symptoms and, sometimes, collapse. Many men, however, are content with less than the highest goals and thereby avoid the greatest pressures. They find satisfaction and security in being second in command, a power behind the throne, or an ever-loyal subordinate.

Any breakdown—any failure of adaptation—is the product of multiple causes. The total interaction of the individual and his environment, past and current, should be studied if scientific answers are to be found. Coronary disease is a case in point. Men are three to seven times more likely—depending upon the sample studied—to have coronary disease than are women; in one series of young adults, the ratio was twenty-four to one. Another factor is body type: men of "athletic build" are more likely to have coronary disease (in younger adult years) than are tall, thin men or short, fat men. Also, in one series of forty-six cases of coronary disease, 50 per cent were found to have been former high school lettermen, and from schools where only 10 per cent of the students won athletic letters. Thus the incidence of coronary disease among lettermen was five times that of high school graduates generally. Other statistics indicate that coronary disease occurs earlier and more frequently in Jewish men than in non-Jewish men. It would appear, therefore, that the stress of executive responsibilities and competition in business must be balanced with body type, history of participation in rigorous sports, cultural background, and multifold psychic factors for a complete understanding of breakdowns or premature death.

***Why are there more widows than widowers? Is increased psychological stress in men a factor?***

There are more widows than widowers because women are the stronger sex. Women are built for childbearing; men simply for impregnation. It may not be so simple, of course, but the famous Canadian pathologist, William Boyd, in his *Textbook of Pathology* says: "There appears to be an inherent weakness in the male, a sex-linked inferiority, so that by comparison with the female he is a weakling at all periods of life from conception to death. This holds true throughout

the animal kingdom. As E. B. Allen remarks, the price of maleness is weakness, and woman is far from being 'the weaker vessel.' "

Other authorities have contended that women live longer because they are the "weaker" sex. Men, being "masculine," dam up their feelings and develop ulcers and high blood pressure. Women, being feminine, are irrational, complaining, and given to tears—and to burying their husbands. This point of view is by no means as well-documented as Boyd's, but there may be something to it.

According to the United States Bureau of the Census (statistics standardized for age), there were about three widows for one widower in 1890, and about three and one-fourth to one in 1958. There has therefore been some increase in the proportion of widows to widowers, but it is impossible to estimate how much the change is due to recent wars, how much to industrial accidents, how much to diseases of older age groups affecting men more than women, and how much to psychological stress. Statistically speaking, women live five years longer than men, and apparently this has always been so.

*Do men tend to be overanxious about their occupational, professional, economic, family, and social status and thereby become more susceptible to mental disorders?*

The report of the Joint Commission on Mental Illness and Health, *Americans View Their Mental Health*, indicates that there is no single answer to this question. Definitions of mental health itself, states the report, are usually made within a framework of middle-class values. Our very diagnoses of mental disorder are tied somewhat to middle-class standards. How then to evaluate concerns about status as a cause of mental illness?

One survey shows that such concerns are minimal in the high income group. It is the middle income group that worries about money and therefore, presumably, about other aspects of status. Older men are generally less concerned about these matters than are younger men; they have arrived at or achieved a plateau, or they have become reconciled. When distress is felt about these matters there are also differences in how it is expressed. Older persons are likely to have physical symptoms of anxiety; younger persons, psychological symptoms. Among social groups, working-class people are more likely to complain about bodily symptoms whereas the better educated and wealthier people are more disposed to psychological modes of expression.

Despite the equivocal nature of our evidence, there is certainly a widespread impression that younger business and professional men

frequently drive themselves to the point of tension symptoms of one sort or another. The use or abuse of alcohol, Benzedrine derivatives, or sedatives, while not necessarily considered indicative of mental disorder, are frequently related to competition for higher status of one sort or another. It must mean something, also, that the suicide rate for men is generally three or four times that for women, and (except for 1910) it was higher during the depression (1930 to 1940) than at any time since 1900. One life insurance company, studying policies of \$25,000 and over, found that the suicide rate from 1929 through 1932 was nearly 900 per cent of what could have been anticipated from the previous incidence of suicide among this group of policyholders. The shame, guilt, and loss of self-esteem connected with business failure is certainly evidence of the intensity of striving for and concern about success. It must be added, moreover, that in normal times the highest suicide rate is among men over sixty-five. These, again, are the retired, the unemployed, and (in their own eyes) the unwanted. The evidence suggests that being overanxious about status is less likely to produce mental disorders than loss of status through failure, unemployment, or retirement without other resources for activity and a sense of worth.

*Does a man's inability to reach job goals—for example, the man who is a perpetual assistant, the executive who is not elected president of a company, the politician who doesn't advance—make for serious mental health problems?*

This is definitely an individual matter. The reasonably normal young man knows that relatively few men "reach the top" and that he himself may have to settle for less. The man who cannot do this is the neurotic one. Granted that American culture is competitive, it is also one that inculcates sportsmanship; one learns to fight the good fight and, if necessary, to be a good loser. Most men with maturity face and accept their personal limitations as well as those imposed by circumstance or fate; and they are not shattered by defeat. The man who develops mental health problems over failure to achieve the highest goals is likely to have had neurotic ambitions to begin with or an unrealistic picture of his capabilities.

*Does the man who once possessed outstanding athletic ability or physical strength have special problems of mental adjustment as he grows older?*

He may, but not inevitably. Again, one must get down to cases. One question to be considered is what makes an outstanding athlete in

the first place. Going out for sports or building up physical strength is a normal, healthy activity, but—where the drive is particularly strong—it may represent an excessive need to escape from fears of passivity, “femininity,” or masturbation, or to compensate for feelings of inferiority. These concerns are particularly poignant in adolescence and young adult life. To the extent that they persist into adult life, to the same extent a man may go on being a body-builder or an athlete long after he should turn to less rigorous pursuits. In a word, if neurotic drives go into the making of an athlete, then neurotic problems are likely to vex him in later years.

There are men whose physical prowess or athletic achievement represents their greatest success. It is only natural for such men to cling to this era of glory as long as possible. Most football heroes, for example, will go on to win their “Y” (or other college letters) “in life”; the few who do not are the pathetic few who remain perennial undergraduates much as another pathetic few are still fighting World War I. If most of a man’s self-esteem derives from his athletic record of bygone days, he may well have emotional problems with the passing years. The over-evaluation of physical prowess is characteristic of adolescence, according to Paul V. Lemkau; and if one clings to such overestimation, one may be adolescent in other respects whatever the chronological age.

*While all men resent decline in sexual prowess, does the factor of increasing social and economic success lessen or aggravate the problem?*

First, it is not true that all men resent declining sexual prowess. Cicero, in *De Senectute*, points out that old age loses its interest in the “baser pleasures” of youth. This may, of course, simply be making a virtue of necessity. Others besides Cicero have argued, however, that when the mind is emancipated from the distractions of passion, it is freer for intellectual pursuits. It is partly a cultural phenomenon that such a premium is placed upon sexual prowess. In some societies sex is for procreation primarily; in others, it is for procreation and pleasure. “Sexual prowess” has still different connotations and represents somewhat different values. In any case many men gracefully accept the gradual diminution of sexual desire and potency; others become hypochondriacal or depressed, paying inordinate attention to gastrointestinal functions or to ailments of one sort or another.

If a man has been a “sexual athlete,” if he has excessive self-esteem bound up in sexual performance, then any decline in his ability will threaten his sense of virility. Again, if sexual decline sets in early—say,

in the forties—when his sexual partner, at thirty-five or so, is at the peak of her sexual interest and responsiveness, then a man may be upset indeed. Thus, a perfectly normal tapering off of sexual drive may seem abnormal if it sets in early, if a man puts too great store by it, or if it happens to coincide with the partner's period of maximum sexual outlet.

Men are less perturbed by declining potency—other things being equal—if they have other supports for their self-esteem. From this point of view, increasing social and economic successes can certainly compensate for diminishing virility. The same may be said for any other creative interests—vocational or avocational.

*Are divorce and remarriage more prevalent among successful men? If so, why?*

No, the divorce rate is lowest among successful men. The results of three independent surveys, reported by Robert F. Winch and Robert McGinnis in their book, *Selected Studies in Marriage and the Family*, indicate that the lowest divorce rate is among men whose occupations can be classified as professional and proprietary (including executives, managers, officials, etc.). Other studies show that the divorce rates drop with the length of marriage. If the average successful man has been married, say, for twenty years and has children, his chances of getting a divorce are about 50 per cent of what they were after five years of marriage; if after twenty years he has no children, about 33 per cent of what they were after five years of marriage. The peak divorce rate for childless couples comes four years after marriage, and this is followed by a sharp drop. The highest incidence of divorce among couples with children comes at three years after marriage, followed by a gradual drop. The rates come closer with increasing years, so that, after thirty years of marriage they are the same for couples with children and childless couples. If the marriage survives the period during which a man is becoming successful, therefore, both the time factor and factors associated with success itself will tend to preserve the marriage.

Statistics about divorce rates and remarriages are, of course, only one index of marital unhappiness. Some who cannot afford a divorce will desert. Fear of scandal or religious reasons will cause others to separate, but not divorce. Marital infidelity is still another solution among all economic groups. Statistics as to desertions, separations, and extra-marital affairs are notoriously unreliable but, according to Alfred Kinsey's report, the highest rates of marital infidelity are among the lowest socioeconomic groups.

***Are men—in their forties or fifties—more likely to become dissatisfied with their family situation and seek a change?***

This question presents a paradox. A study by the Joint Commission on Mental Illness and Health revealed that men (and women) in their forties and fifties are less happy in marriage than younger couples, but at the same time they have less feeling of inadequacy in marriage and report fewer marriage problems. We have already seen that the divorce rate decreases with increasing age and length of marriage. It would appear, therefore, that older couples may be less happy, but at the same time expect less and therefore are better reconciled to what they have. These findings correspond to still another study which indicated that older people are generally less happy than younger people, but are nevertheless not so worried. Happiness and the awareness of problems or a tendency to worry are therefore not correlated.

If men in their forties and fifties do become dissatisfied with their family situation, they do very little about it—statistically speaking. It has been mentioned that they may seek various ways of denying their increasing age, but this seldom leads to divorce and remarriage. Extra-marital affairs are not uncommon, of course; but the more general realignment of interests might be expressed as “more club life or more ‘pub’ life.”

There are centripetal as well as centrifugal forces in a marriage that has lasted twenty years or more. Apart from a man’s search for some “fountain of youth,” he is generally more tolerant of life than before and more philosophical about its frustrations. This mellowness generally includes his sentiments toward his wife and his marriage. Besides, as the children grow up, husband and wife often rediscover one another and enjoy more companionship than has been possible for years. Beyond this, the vicissitudes of middle age—the loss of children to college or marriage, more frequent illnesses, and the like—often increase their mutual dependence and thereby strengthen emotional bonds.

***Is there a climacteric in males? Does it involve any physical changes? Do all men to some degree experience climacteric? If so, does it affect their mental health?***

The question of a male climacteric is controversial. The term “climacteric” implies a relatively dramatic, critical, and definite change. The menopause is such a change, but this has no physiologic counterpart in men.

Changes in men that might be considered as a climacteric are in part



those of progressive aging and in part the occasional emotional reactions resembling those that can be associated with the menopause. Men may complain of diminishing sexual desire after the age of thirty and of diminishing potency after forty, whereas according to Kinsey, the maximum sexual output for women comes at about thirty-five and—menopause or no—drops less rapidly than is the case with men. Diminishing sexual drive is, however, only one aspect of advancing age. There are a number of endocrine changes occurring in both sexes that make for such phenomena as the “middle-age spread,” redistribution of subcutaneous fat, muscular flaccidity, and so on. The general effect of all such changes is that the sexes tend to look progressively more alike with advancing age.

From a psychological point of view, there are two sets of phenomena that sometimes suggest a male climacteric. One set already noted, are neurotic reactions to middle age, the various “denial” reactions that are calculated to convince a man that he is as young, strong, and virile as ever. The second set are the depressive reactions that in men come as a rule about ten years later than the “menopausal depressions” of women. In men these emotional disturbances, coming between fifty-five and sixty-five as they frequently do, have been considered evidence for a male climacteric, but they are probably more the product of increasing fatigue, diminished efficiency on the job, the prospect of retirement, or the fact of retirement itself coupled with the sense of uselessness and self-depreciation. Actually the sum total of emotional responses to approaching or definite retirement is probably the true male climacteric.

*Is there a relationship between disorders of the prostate gland and mental health? How many males experience these difficulties?*

There is no direct relationship between the prostate gland and mental health. Disorders of the prostate gland, by the same token, do not as such cause mental health problems. It is only the rare textbook of psychiatry or urology (disorders of the genito-urinary systems) that even suggests such a connection.

Slight to moderate enlargement of the prostate gland is normal with advancing years. Sixty-five per cent of men will have some enlargement of the prostate at the age of sixty-five. The cause is thought to be some endocrine imbalance, probably between the testes and the pituitary gland, but in any case it is virtually limited to the presenile and senile periods of life. Such enlargement may increase the frequency and prolong the duration of urination. Serious interference with urination

requires surgery. When mental health is affected, it is because of real or fantasied reasons for, and effects of, prostate trouble. There will be normal anxiety as with any other illness or disturbance of bodily function. There may be an accentuation of concern about advancing age with related feelings of despair, depression, or a sense of defeat. A few individuals attribute such afflictions to adolescent masturbation, to sexual excesses, or to "fast living" in general, and therefore suffer from shame or guilt. Statistically, however, there is no more reason to link prostate disease with mental illness than any of a number of other diseases common to middle age and beyond.

*Should men take vacations without their families in order to get complete relaxation and ease of tensions?*

Some men should, but perhaps the majority should not. One has to ask: What are the sources of tension for a given man, and what provides complete relaxation? There are many related questions: What kind of marriage is it? How old are the children, and how does the man react to them? How long will the vacation (separation) last, and how well do members of the family tolerate separations? Many married couples find occasional brief separations refreshing and enriching if only because they miss each other and are reunited with greater appreciation for their marriage, but for long vacations the majority prefer to be together. The question of whether the children are to be included has to be considered separately.

There are both positive and negative reasons for family vacations. If the marriage is a good one, it is a matter of greater enjoyment. If family life is generally congenial, even the irritations of young children are outweighed by experiences of family unity and adventure. To a considerable extent, the delights and explorations of children on vacation are a source of pleasure and satisfaction for both parents. From a negative point of view, the man who enjoys himself apart from his family is likely to feel irresponsible, guilty for his "selfishness," and worried about how things are going at home. If, of course, a major source of a man's tensions is at home—because, for example, of a chronically unhappy wife or children who constantly irritate him—then a separate vacation may be best for him and for his family. Family traditions, patterns of interaction among members of the family, emotional attachments to relatives or others outside the immediate family, and economic circumstances are just a few of the other factors to be considered.

***Is it important to a man's mental health to have some recreation away from his family, such as golf, bowling, or a card-playing night with his friends?***

It is certainly important for a man to have hobbies, avocational interests, or other recreational activities. An early observation at the Menninger Foundation was that almost none of their middle-aged male patients had such interests. Prescriptions for the learning of hobbies soon became as important as prescriptions for medicine, and even more frequent.

Most men probably prefer some recreation away from home. The man's night out is so common in American culture that we can only assume that it meets important emotional needs. From one point of view it is a normal continuation of adolescence into adulthood or, to put it another way, a normal expression of sublimated homosexuality. Something of the infant, child, and adolescent remains in all adults, and only excesses are pathologic. In any case, it is "normal" to want to be with "the boys" occasionally.

***Should a person have periodic psychiatric checkups as well as physical ones? If this is a useful idea, where should the individual go in order to get help in the choice of a doctor?***

William C. Menninger recently made precisely this recommendation at a Menninger Foundation seminar for executives. "One aspect of the emotional checkup," as Menninger described it, "can be self-administered. Take the time at least once a year to ask: Where am I going? What are my ambitions and aspirations? What are my priorities? Take inventory," he suggests, "not merely of the business situation but also of important personal areas: the home atmosphere, family relationships, feelings of self-esteem, dignity, and integrity. Take vacations," he adds, "and cultivate hobbies; the more seriously a man takes his hobbies, the richer his life will be."

Other aspects of a psychiatric checkup are better done with another person, possibly a psychiatrist or other trained counselor. A family doctor can do the job if he has the training and will take the time required; or he can recommend someone. Discussions with such an expert will cover such matters as interpersonal relationships at work, in social situations, and at home; reactions to stressful situations; ability to withstand frustration; indications of anxiety or other tension; opportunities for creative effort—not hobbies merely, but also those including giving of oneself to others; and, finally, the ability to seek help when indicated, rather than denying the problem or procrastinating indefi-

nately. This form of preventive medicine is in its infancy, but it is quite possible that psychiatric checkups may someday be even more rewarding than routine physical examinations.

*Does compulsory retirement create special mental health problems for men?*

Retirement is a mental health hazard under any circumstances. Compulsory retirement, anticipated and carefully prepared for, is preferable to the frequently painful "voluntary" retirements or the even more painful forced retirements precipitated by failing health or other unexpected circumstances. Ideally, at least, compulsory retirement at, say, sixty-five may be compared to navigating by a fixed star; and other kinds, to drifting in a fog of uncertainty and doubt.

The virtue of compulsory retirement from a mental health point of view is that it is a "known" and can therefore be planned for. Its success will, of course, depend upon the quality of the planning. The man who knows when he is to retire can chart his course; he will, for example, gauge his savings, moderate his spending, develop his avocational interests, and decide where and how he wishes to live after retirement. He can avoid having all of his eggs in his vocational basket and, depending upon circumstance, he can consider retirement homes, change of climate, less rigorous activities, travel, part-time employment, shift from executive to subordinate responsibilities, and so on.

The case against compulsory retirement at a fixed age is that it deprives society of highly developed skills and talents combined with wisdom and maturity of judgment, and that it may come as a body blow to the self-respect and self-esteem of an individual who, often enough, feels himself to be at the peak of his powers. The blow is greater, however, if it comes without warning, as is generally the case when retirement has to be "suggested" or imposed by embarrassed colleagues or superiors. Plans for gradual retirement have proved successful in some academic and business settings. The most important aspect of retirement, however, is not so much whether it is compulsory or not, but rather how well it is planned for; and whether the planning involves some long-range program as opposed to a sudden upheaval.

Justice Oliver Wendell Holmes, at ninety, resigned from the Supreme Court a few hours after his voice failed him in reading a decision. Few men are so wise or so courageous; and few men should work so long. A Holmes is the exception that proves the rule of planned retirement.

*Is volunteer community work (for civic groups, churches, fund-raising drives, children's organizations, mental health programs, etc.) a mentally healthful activity for a retired man? What might he be able to contribute, and what are the personal rewards and satisfactions he might experience?*

Volunteer community work is definitely a mentally healthful activity for a retired man. One of the principal dangers for a man who retires at sixty or sixty-five is that he will feel unwanted, useless, and unimportant. Active participation in community work precludes such causes of apathy, depression, and deterioration by sustaining his interests and his sense of sharing in vital endeavor. Adlai E. Stevenson, United States Ambassador to the United Nations, suggested the Peace Corps as another such opportunity, and said that we should tap the large number of senior citizens of unusual knowledge, skill, and experience who would welcome the opportunity to be of service. Whether one's community is the world or the neighborhood, there is work for an older man to do that brings really lifesaving satisfaction from doing it.

Retirement sometimes accentuates fears of old age and senility. Recent psychiatric research indicates, however, that senility is more a state of mind than an organic disease. At the Topeka (Kansas) State Hospital, for example, patients diagnosed for years as senile and deteriorated have been rehabilitated and returned to community living by recreational and occupational projects suited to their physical skills. Senility was once considered the inevitable result of arteriosclerotic brain damage, but at least one research study revealed that a group of patients suffering from so-called senile dementia had less extensive organic changes in the brain than another group of the same age bracket who led active intellectual lives until they died. To the extent that senility is a mental rather than an organic disturbance, it can be prevented; the best way for a retired man to prevent it is to keep busy at interesting and useful work.

# AGGRESSIONS

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## ***What are aggressions?***

In its broadest sense, the term *aggressions* refers to the total amount of energy expended in actively striving to satisfy instinctual, or inborn, drives. In the human being we prefer to speak of *drives*; in lower animals we see the aggression as a way of dealing with *instincts*.

In a narrower sense, the psychiatric meaning of aggression refers to forceful attacking action that can be either physical, verbal, symbolic, or all three.

It is the purpose here to focus attention on a particular category of behavior, namely the human aggressions that differ, both in quality and quantity, from the usual or normal form of active striving. Since these forms of activity differ from normal, we sometimes refer to them as antisocial or criminal. These aggressions are a problem for the individual, the family, the state, and the world at large.

## ***Is there a difference between the layman's definition of aggression and the psychological definition of aggression?***

Yes. The layman's definition of aggression is based primarily on a moralistic point of view. Fundamental in this definition is the concept that man is the master of his will. In keeping with such definition society, over the centuries, has created laws with which it attempts to protect itself from aggressions. For example, the basis of contemporary Anglo-Saxon criminal law is the "Knowledge of right and wrong" test, and dates back to a decision in the courts of Great Britain in 1843. That decision led to the M'Naghten Rule, which says that a man is not responsible for his act if he does not know the nature and quality of the act, or if he does not know that what he is doing is wrong. A jury in deciding the guilt of an accused must decide whether the person in question "knows right from wrong," and not whether he is mentally ill.

In the psychological sense, aggression is recognized as the active in-

gradients of inner strivings over which the person has only varying degrees of control. The amount of control will depend on the specific situation. Of course, the layman is aware of this, and even though his approach is moralistic, he will make allowances for such things as "acts of provocation," "self-defense," and other similar circumstances. Thus, society—a group of laymen—does take notice of the dynamic forces involved in aggression.

*Are there various kinds of aggressions?*

Yes. There are aggressions that develop slowly and in keeping with day-to-day problems and frustrations. This happens particularly during the growing phases of human development. These aggressions may be a reaction to too much discipline—or to too little. When there are excessive prohibitions, the young child may feel a need to mobilize constantly increasing amounts of aggressive energy to cope with his frustrations. Where there is a lack of organized discipline, the child may feel that he is being left on his own too much, and he then becomes anxious. This anxiety can stimulate aggressions in order to provoke his elders into giving him more protection and guidance. Such aggressions are an expression of the child's sense of insecurity.

Aggressions may be rational or irrational. Rational aggressions are most often a response to actual situations in the life of a person and most often they are justifiable. The irrational aggressions usually result from some inner mental attitude that compels the individual to act aggressively.

*What causes aggressions?*

Essentially, aggressions are caused by frustration or interference with a natural development of the instinctual drives. Since the life of a human, even in its earliest phases, encounters checks on its instinctual drives, frustration is ever present. The quantity of frustration, the capacity for its tolerance, the amount of support given the child by his parents, or lack of it, and, later on, the support given by others, all contribute to the ultimate degree of aggressive feelings.

Some of the factors that cause aggressions are "constitutional," which means that something is present from very early life, possibly from birth. This something may emerge as a lack of capacity to develop emotions, or an absence of tolerance for frustration, or a lack of ability to adjust to the demands of outer realities of everyday living.

The extent to which constitutional factors operate will also depend on the atmosphere in which they develop. Parental incompatibility, broken homes, alcoholism in one or both parents, unethical practices by parents—are some of the many determinants that color the development of aggressive impulses in the young. It is not difficult to see that any of these factors can cause feelings of disappointment and aggressive reactions. The “black sheep of the family” frequently develops from a combination of constitutional and environmental determinants.

Prolonged and serious illness, particularly at a very early age can, and at times does, lead to abnormal emotional reactions, including a moderate percentage of aggressions. Such illnesses would include significant birth blemishes, crippling after birth, and the “accidents of nature.” Studies since World War II have demonstrated that very young children who are ill and require hospitalization need the mother near them even though the facilities of the sickroom may be excellent.

Aggressions develop and exist not only in an individual, but also in many individuals acting collectively, namely society. Poverty and hunger lead to much frustration. Although economic frustration is not the only cause of the aggressions in society, which we call crime, it is often an important factor.

Perhaps the biggest cause of aggressions is anxiety, another term that refers to inner and outer feelings of uncertainty. Anxiety can cause even “a fine man from a good family” to steal from his employer. Group anxiety can lead to the enactment of laws and regulations that in some instances are themselves expressions of much injustice and aggression; for example, laws and regulations imposing censorship on art and communications. Finally, the anxiety of nations, both strong and weak, can ultimately lead to wars. From a psychological point of view, war is the ultimate outcome of the individual's aggression multiplied a millionfold. (See *Anxiety*)

*Is some degree of aggressive behavior considered normal, or even desirable?*

Not only is some aggressive behavior considered normal, it is *essential* for self-preservation and for achievement of goals and ambitions. Aggression in a neutralized form is also an essential part of all human activity, inasmuch as by our definition it is in a sense the overt manifestation of the utilization of energy.



***Do all individuals exhibit certain aggressions?***

Certain aggressions must be present in all human beings. What is important, however, is not only the presence of aggressions, which are basic and necessary, but rather the amount of conscious control over them, the degree of awareness of their rational usefulness, and finally the ability to direct these aggressions into creative and constructive channels.

***How are aggressions expressed?***

It is through aggressive behavior that the productive utilization of human drives permits the individual to function in all aspects of life. The utilization of aggression is evidence of the capacity for healthy functioning, whether the aggression is used in performing essential daily chores or in a sudden act of self-defense. When we speak of self-defense, we do not mean defense only against other human beings, but also against all the forces and problems that beset man.

Criminal behavior is an extreme form of aggression but need not always *appear* to be aggressive. We must be aware that aggressions do not necessarily show themselves overtly or violently. Aggressions may be expressed in subtle ways that seem to be imperceptible. This is particularly true of individuals who are able to harness aggressive feelings and impulses but cannot channel them into useful productivity. Instead, they may use these feelings for purposes such as scheming, scandal-spreading, or maligning.

***When do aggressions work negatively toward the person who harbors them?***

Aggressions of this kind occur most frequently in the person who does not have a conscious recognition of his aggressive impulses, or who develops unconscious reactions to oppose these impulses. For example, because of interferences at some stage of a person's development, his aggressive impulses are thwarted. These impulses because they are so frightening, are replaced with a rather bland and even self-subjugating kind of attitude that may lead to the development of obstinacy or similar undesirable traits. Aggressions can also work negatively toward the individual by impelling him to do senseless and useless acts that if repeated often enough could seriously interfere with his adjustment in the home, on the job, or even with society. For example, a middle-aged successful businessman had suppressed many of his aggressive feelings

toward his dead parents. In his home he frequently shouted at his wife and children, and accused his wife of not rearing their children properly. In his calmer states he felt genuine concern for his entire family, and worked hard to give them "everything they wanted." In another instance, a man in his mid-twenties had a need to be "the best" driver. Frequently the police caught him violating traffic rules. On many occasions he had difficulty with other drivers whom he attempted to "beat out" on the road.

In both these men, a great deal of aggressive behavior was used in a way that was extremely injurious to themselves.

*What can be the far-reaching effects of intense aggressions, especially on the family? On the job? On social relationships?*

An aggressive person, particularly one with little control over his impulses, is rarely able to establish and maintain wholesome and lasting relationships with others. In his earlier years, he will be in frequent conflict with his parents and other members of his family. He may become involved in delinquent behavior outside the home, and this will further aggravate his troubles in the family group. As he gets older, he may in certain instances, especially during courtship, attempt to control his behavior. Soon after marriage, however, the abnormally aggressive individual (man or woman) is likely to give full expression to his drives, and this inevitably will disrupt the marital relationship. Frequently, in such a situation, his spouse may seem willing to tolerate his aggressions only to discover that the children too, have become the targets of a great deal of the aggression.

In our society a job can involve a complicated interpersonal relationship even if the job itself is of a simple type. Therefore, abnormal aggression can seriously interfere with a person's wholesome companionship with co-workers and appropriate adjustments to those whose status is above or below his own. When an aggressive person can arrange to have his own business, he may manage to achieve varying degrees of success. Sometimes he may be surprisingly successful and then he creates many problems for those whom he employs.

The abnormally aggressive individual often expends much energy attempting to surround himself with friends, and then boasts of these friendships. This is particularly true of persons who have achieved positions of power and who have surrounded themselves with fright-

ened and subjugated followers rather than with loyal friends and companions.

***What causes the aggressive personality?***

The aggressive personality results from the coloring of the individual's total personality by unbridled and frequently unorganized aggressive impulses.

***Are certain aggressions symptoms of another problem?***

Sometimes a person's aggressive behavior may be a symptom of a rather frightened and anxious inner self that needs to deal in an explosive manner with wishes and strivings. The so-called normal tendencies then become inhibited, and after periodic episodes of inactivity, there may be bursts of energy in quantity and quality so different from the person's usual behavior that they appear to be aggressive.

In some instances, aggressions can be symptoms of mental illness.

***When do aggressions usually begin?***

In general, aggressions tend to begin at certain critical periods of life. Aggressions may make their appearance in adolescence, the period when the young human being is struggling with many adjustment problems. Some aggressions may appear before, others after puberty.

***Do the kind or intensity of aggressions change or disappear in the aging process?***

Without question, the answer is yes. Aggressions frequently appear in the formative adult years. As a person grows in maturity and experience, he is likely to have fewer and weaker aggressive feelings or to channel them into more useful and socially acceptable activities. Indication that such is the case may be seen in the statistics showing that the late teens and early adult life are the periods with the most representation in penal and correctional institutions.

***Is it natural for an adolescent to show aggressions?***

It is natural for the adolescent to show aggressions. The teen-age child who is "always very good" or a "model child" is most likely suppressing his feelings, and not developing in the best way. If parents can tolerate some aggression and understand that it is "healthy," rather

than "naughty," there will be fewer problems in the home. At times a very aggressive parent cannot tolerate *any* aggression in his teen-ager and this will lead to much conflict in the child, possibly with most unfavorable consequences.

Aggressions can be channeled into productive, useful activity both in the home and at school. Work in all its forms is a wonderful experience for the growing child. Such work can be quite individual. Sometimes a disturbed, overaggressive boy, when helped to become a member of a team, will soon find that aggression can lead to pleasure, acclaim, and accomplishment. "Understanding" is a word that is frequently misunderstood. To understand an aggressive teen-ager is not the same as giving in to him, indulging him, or being afraid of him. There are parents who become afraid of their children, and the results can be extremely harmful. It would be most useful if more parents and educators recognized that the teen-aged, apparently aggressive, person is seeking to be "understood" *and controlled*. Only then can this teen-ager realize how important he is to both parent and teacher. Workers in boys' clubs, community centers, and similar organizations, generally recognize the significance of aggression and help the young people to "work it out," both physically and emotionally, often with excellent results.

Rigid disciplinary reactions—either strict or permissive—whether in the home or at school—that do not take into account the needs of the individual child, can lead to more trouble. Unfortunately there are homes where the word *discipline* is equated with punitive acts. Discipline in its broader sense is an essential requirement in any group, small or large, and unless it prevails in the home during the earliest years of a child's growth, he will become confused.

Some years ago, a question was put to an expert at a parents' meeting at a private elementary school by the mother of a seven-year-old girl. The mother, a college graduate, eager to bring up her child in accordance with scientific principles asked, "What can I do when my daughter kicks me in the shins?" This mother revealed her confusion about basic principles of child rearing and home discipline. Most likely the little girl had already sensed her mother's uncertainties and was taking advantage of them. Some parents and teachers think that to deny a child his wishes means to "traumatize" him. This is a gross misconception. No scientist has ever said that the best way to bring up children is to leave them to their impulses.

***Do some aggressions recur after they have subsided?***

Aggressions can recur. Such a situation may be brought about by sudden and unpredictable changes both in the outer life of a person and the mental processes within him.

***What treatments are available to reduce aggressions? What is their success? What determines this success?***

Society long has recognized that some aggressions can be reduced, and it has attempted to do this by utilizing penal methods. These methods cannot be evaluated for their curative worth inasmuch as the aging process itself plays an important role. Frequently the experience of being in prison—or even being on probation, which many authorities consider preferable to imprisonment—affords an opportunity for reflection, self-examination, and an increased capacity for adaptation. In more recent years it has been demonstrated that increased understanding of the circumstances under which aggressions appear, followed by efforts to modify the outside environment as well as to promote more self-understanding by the patient, can be extremely helpful. The latter procedure, of course, falls into the category of therapy, which has been a responsibility not only of psychiatrists and psychoanalysts, but also and increasingly has been effectively practiced by probation officers, social workers, perceptive and tolerant guards, correction officers, and all those charged with the responsibility of caring for the delinquent. Many lawyers, and particularly judges, have shown keen understanding of the meaning of aggression, and an increasing number of judges are following the principle that, where circumstances permit, it is better to fit the punishment to the criminal rather than to the crime.

Treatment of aggressive persons is successful most often when their individual patterns of behavior are understood not only in the light of social requirements but also in terms of their inner strivings and frustrations.

***What measures might be taken to prevent aggression from occurring or increasing in intensity?***

Reduction in tension and frustration at the individual, family, or group level will frequently prevent the occurrence and persistence of aggression. This has been known for many years, and the principle has been used by educational institutions, by various organizations (social, sports, etc.) for children and adolescents, by political groups, by study

groups, and by innumerable other groups whose purpose is to channel aggressive energy into productive and creative behavior.

***Based on current research, what might be predicted about the prevalence and intensity of aggressions as a mental health problem?***

There is a close relationship between mental health problems in general and the aggressions specifically. It can be predicted with some degree of certainty that the greater the effort to deal with aggressions during their early manifestations, the better will be the mental health of the individual. Since aggressions, statistically, appear to be more troublesome among the young and growing, it is certain that increased efforts to reduce aggressions can significantly improve mental health.

# THE AGING AND THE AGED

by EDITH M. STERN, B.A.

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## *Who are the aging?*

"The aging" is a euphemistic way of referring to "the aged" or "the old people." Actually, we are all the aging, for we are constantly growing older from the moment we are born. The specific group, however, known for purposes of convenience and common understanding as the aging, are those sixty-five or more years of age. The figure, sixty-five, is taken from the Federal Security Act of 1935, and is arbitrary. Science knows no fixed birthday that marks the beginning of old age.

## *How many persons in the United States are aged?*

By 1962, more than 17,000,000 Americans will have celebrated their sixty-fifth birthday. By 1975 there will be an estimated 20,000,000.

## *What is the aging process?*

It is the decrease, as time goes on, of a living being's ability to adapt to its environment. Some familiar physiological evidences of the aging process are the relative length of time it takes old people's broken bones to knit or for them to regain their strength after a bout with illness; the slowdown in their movements; the dimming of vision and hearing; and the difficulty they have in withstanding extremes of temperature. Psychically, the aging process may show up in decreased ability to accept new ideas or to fit in with new places or new people.

As yet no one really knows how much of such deterioration is inevitable and "natural," the result of pathology (disease), or of the way the aged are treated in society. Theoretically, unlike machines, living beings need never wear out, for the cells that compose the tissues and organs of the body have the capacity to replace and renew themselves. When they do not, it is because something interferes. This is equally true in youth and in age, but the aged's ability to resist stress is less.

Much research is being done to discover more exactly the whats and the whys of the aging process.

***What happens to mental abilities as the body ages? Does the I.Q. change in older persons?***

According to numerous psychological experiments since 1925, mental abilities decline with age. This conclusion has been reached despite due and careful allowance by researchers of factors such as lack of motivation of the aging as compared to that of younger folk, diminished speed in performing tasks, ill health resulting from the relatively poor nutrition and medical care of old people living on low incomes, the better education of younger generations, and emotional factors such as loneliness and family difficulties. Some psychologists have questioned whether the tests themselves do not need revision to provide for scoring of originality and the higher forms of judgment, in which older persons might show up better than younger ones. Presently, however, according to the *Handbook of Aging and the Individual*, edited by James E. Birren, there is overwhelming evidence in spite of any and all modifying circumstances that the I.Q. does change downward in later life. The downgrade, however, is least marked in individuals of superior I.Q. and education.

***Is the rate of aging a constant one, or does it accelerate or decline?***

The rate of aging is variable. It is affected by many factors, among them nutrition, exposure to infection, the conditions under which a person lives, injury, and emotional adjustment. An abrupt event, such as retirement or a heart attack, can accelerate aging. A new later-life interest or satisfaction can slow it down.

The rates at which individuals age differ greatly. At seventy, one person may seem years younger while another may seem years older.

Moreover within one individual, different organs may age at a different rate. The lungs, for example, may be aging much more rapidly than the eyes, or the other way round. Similar differences in the rate of aging apply to the mind and emotions. Someone with rapidly aging legs may remain for a long time young in outlook and mental vigor.

***Can an aging person himself do anything that might decelerate the aging process?***

Barring an Act of God, yes. Periodic medical examinations can prevent avoidable physical deterioration. Some of the chronic diseases that afflict the aging have their onset before symptoms are evident, and can be arrested or cured if discovered early enough. Keeping weight down



to what it should be, not only furthers movement and activity, but is also less of a strain on the heart.

New intellectual and cultural pursuits, or maintaining former ones, help to prolong activity. Sympathetic interest in other people tends to prevent the self-centeredness that may worsen into complete withdrawal. Above all, a lively curiosity and concern with the present and future rather than continual harking back to the past, can make an elderly person not only seem but really be "young for his age."

***What happens to the sex drive in the aging person? Is sexual contact physically dangerous for older persons?***

It diminishes but does not cease. Alfred C. Kinsey found "little evidence of any aging in the sexual capacities of the female until late in her life." Determination of the effects of age on women's sex drive is more difficult than on men's, however, because "a considerable portion of the female's sexual activity does not result in orgasm."

Measuring men's sex drive by the frequency of orgasms per week, Kinsey found that it almost steadily decreases from over three a week at twenty to less than one at sixty. Changed physiological capacity primarily accounts for this. But psychological factors—loss of interest in an often-repeated experience, exhaustion of possibilities for exploring new techniques, contacts, and situations—may play a part too. Kinsey reported that change of sex partners and sexual techniques increased frequencies in older men, although fairly soon they returned to their previous frequencies.

Unless expressly forbidden by a physician, there is nothing physically dangerous about sexual contact for older persons. At no fixed age does it need to go into retirement. A few years ago, *The New York Times* interviewed a number of British and European men, internationally known for their current political or artistic achievements in their seventies or eighties. Almost every one reported leading an active sex life.

***What are some of the special emotional problems of older people?***

One of the most common and poignant is loneliness. The older one grows, the more relatives, friends, and contemporaries one loses through death. More than half the women sixty-five or older are widowed and one-fourth of the men in the same age group are widowers. Some who live to a very great age survive their children.

Even those who have living children may be isolated. This is espe-

cially true of city-dwellers. Older people tend to stay on in the changing, decaying centers of cities where they have always lived, while the young people move to the suburbs. Or the children of both urban and rural old parents are likely to be living far away in this time of moving about on the job.

The great majority of old people, undernourished and often ailing, who are barely surviving on pitifully inadequate incomes are isolated most of all, for they do not have the means nor perhaps the strength to go out. A Senate Subcommittee on Problems of the Aged and Aging captioned the photograph of a humble set table: "The lonely meal. Nothing is more mentally devastating than the confinement, without friends, to inadequate housing to spend the days eating by oneself." Beneath a photograph of stairs in a cheap rooming house was written "The long, steep staircase might as well be the iron bars of the cell for many aged. The difficulty in descending or climbing stairs such as these keeps them confined to their small room."

The sense of insecurity that comes with waning physical powers bedevils many old people with fears. "I got through this winter, but I'm getting so unsteady on my feet, would I be able ever to go out another one?" "I can still read, but my eyes are getting worse. . . ." "What if I became *really* sick? Who would take care of me? How would I pay the doctor?"

As someone grows older, he has not only the problem of adjusting to one loss after another, but also does not have youth's opportunity to find substitutes or replacements. First—usually harder on women—the children depart. Next—usually harder on men—at retirement away goes the job and the contacts that are part of it. Prestige in the community may disappear with the end of work-life. For those who put great stock in their sexual attractiveness or good looks, aging brings further deprivations. Indeed, it is not easy for anyone to adjust to his image of his own body, to wrinkles, thinning hair, thickened ankles, baggy cheeks, prominent joints, and other changes in an obviously no longer youthful self.

Depression is so usual in older people that it is sometimes considered a normal part of the aging process. Maurice Linden, Director, Division of Mental Health, Philadelphia Department of Health, does not hold this view, but considers it the result of society's rejection and isolation of the aged. Moreover, he points out, "Since the older person of today was the youngster of yesterday . . . he himself contributed to the atmosphere wherein youth is overvalued and age is rejected. He there-

fore rejects and hence dislikes himself, and 'this inner-directed hostility leads to depression.' "

***What is meant by the statement that "older people need to continue to feel needed and useful"?***

Throughout life feeling needed and useful is fundamental to emotional health. Teachers recognize this when they give a discouraged slow-learner some little job within his capacity, such as wiping the blackboard or emptying the wastebasket, and praise him for carrying it out responsibly. During maturity the business of bringing up a family and earning a living almost automatically satisfies the need to be needed.

Then comes compulsory retirement, equivalent to saying, "You're no longer useful." As time passes, an older person can come more and more to feel "on the shelf," for our society has no real place for the aging. Someone, or the older person himself, has to create one for the sake of his morale.

Since in our culture getting money for what one does is an important sign that an individual is productive, paid work of some kind gives obvious reassurance. But this is not always feasible or even desirable, as in the case of a housewife who never did have any paid job and does not want one. There are other ways in which older people's need to continue to feel needed and useful can be met, among them volunteer service, church, and civic activities. Some are able to feel needed and useful through helping their children or doing neighborly kindnesses. The means are less important than the good feeling they bring about.

***Is it true that retirement is sometimes followed by a rather rapid decline in health and spirits?***

Yes. Recognition of this has made many industries encourage their employees to prepare for retirement. One large company surveyed its retirees and found that those who had made retirement plans well ahead of time were enjoying a more successful retirement than those who had not. A guideline for a mentally healthy retirement is that one not only should retire *from* but retire *to* something.

***Does the aging process involve the development of certain personality traits which affect the behavior of older persons?***

No new personality traits develop as a person grows older. What happens is that during the younger years personality traits that were

not very prominent, show up more and more. A stereotype of what "old folks are like" is as untenable as what thirty-year-olds are like. The aging process does not turn an aggressive, dynamic young woman into a calm, resigned old lady who sits with her hands folded like Whistler's mother, nor an interesting, affable middle-aged man into a cranky old bore.

*Does the memory grow poor? Why can some aging persons remember the distant past better than the recent past?*

Less is scientifically known about memory in aging than in youth. Loss of memory does not, however, seem to be a major factor in mental decline, for older persons do relatively better in vocabulary and information tests, which involve memory, than in other types of mental tests.

When an aging person is unable to remember recent events or facts, it is not so much due to difficulty in retaining new associations as it is in forming them. Another cause of seeming forgetfulness is that the older one is, the more one has to forget: a mass of remembered material accumulated over the years gets in the way. Also, what happened or what was learned in the distant past may have been much more important at the time and made a much deeper impression than anything in the recent past. Unconscious emotional factors may make an old person, as it may a younger one, unconsciously want to forget. There might also be deterioration in the nervous system, although except in cases where there is disease this is likely to be minor.

*Can new skills be learned or new subjects studied, effectively, by the aging person?*

Yes, as many aging men and women enrolled in adult education classes throughout the United States can testify. In many fields, experience and judgment acquired over the years more than make up for slightly decreased speed in learning. The important thing for effective learning and study in the later years is that the learner must really *want* to know the new subject or acquire the skill. With proper motivation, the handicap of age can be negligible. The famous painter, Grandma Moses, is an often-cited example of someone who acquired a new skill late in life: she had her first art exhibition when she was eighty. Although the talent of a Grandma Moses is a rarity, more ordinary mortals need not resign themselves to believing "You can't teach an old dog new tricks." Human or canine, you can teach him any new tricks he really sees a point in making the effort to learn.

***Are there certain mental disorders—neuroses and psychoses—which afflict the aging especially?***

The two most common mental disorders which afflict the aging especially are cerebral arteriosclerosis and senile psychosis, sometimes called senile dementia. Among persons sixty-five or over, admitted for the first time to public mental hospitals, 85 per cent have one of these diseases or, since they can occur in combination, both.

In arteriosclerosis, the arteries of the brain harden and not enough oxygen reaches the brain for it to function properly. Although in the long run the condition worsens, it fluctuates and the patient has periods of clarity and improved thinking.

Senile psychosis involves impairment of brain tissue. This condition becomes progressively worse. Both arteriosclerotics and seniles usually suffer from confusion, restlessness, and impairment of memory. Arteriosclerotics tend to have more recognition of their limitations than seniles do.

The decreased resistance of older people makes them more vulnerable than younger ones to psychoses caused by infection, toxins (poisons formed in the body), head injuries, and circulatory disturbances, although such psychoses are by no means limited to old age. Two diseases, uremia and diabetes, are the most common causes of mental disorders resulting from metabolic disturbances (disturbances in the chemical processes of living cells). Uremia nearly always is recognized before there are mental symptoms. Diabetes may be undetected in the absence of medical examination.

Mental disorders that are the product of known physiological change are called organic; those in which known physiological damage or deterioration is absent or minor and incidental, are called functional. Because of their special insecurities and deprivations, the aged are subject to functional disorders but these disorders in themselves are not special to old age.

One neurosis more common in later life than in the earlier years is hypochondriasis. The chronically complaining old person, deprived of outlets for his energy and interest, centers his thoughts upon himself and his body. Another neurosis—insomnia—although encountered in the young, occurs particularly in the person whose remaining years on earth are surely few and who is afraid to go to sleep because he equates sleep with death. Depression is another common neurosis of the aged, but it is not limited to the aged. Many other neuroses of the aged are

simply intensifications and manifestations of neuroses that had been present lifelong but in the more active life of before had been successfully concealed or disguised.

***How prevalent is mental disorder among the aged?***

It is difficult even to make an educated guess.

***Are "mental breakdowns" more frequent among the aged living in cities than among those in rural communities?***

One might surmise that the stresses of city living would bring about more "mental breakdowns" than occur in the country. But there is really no way of telling. Records of some public mental hospitals do show that more patients come from urban than from rural regions, but admissions to mental hospitals do not afford a valid measure of breakdown.

What the mental hospital admissions reflect are a variety of family and community situations. Often it is easier to keep a mentally disordered old person at home in the country than it is in the city. On the other hand, psychiatric outpatient clinics readily accessible in a city may prevent breakdown; in a rural region, with the nearest psychiatric facility hundreds of miles distant, the old person, untreated, may go from bad to worse. The reputation of the particular state hospital affects both urban and rural family decisions on whether to have an elderly relative admitted. The extent of families' education and their favorable or unfavorable attitudes toward psychiatry also influence admissions. Further studies which take into account all the variables are needed before this question can be answered.

***Are the aged today in better physical health than were the aged of former times?***

On the whole, yes. The average older person stays on his feet and is able to do much more for himself later in life than was formerly the case. The appalling number of aged men and women bedridden in nursing homes and hospitals for the chronically ill seems to give the lie to this affirmative answer. But one has to remember that these persons would not have been alive at all in another day. They would have died of pneumonia or one of the now-conquered infectious diseases or of a chronic disease, e.g., diabetes or heart trouble.

***How is life expectancy changing from former times? How is it likely to change in the next generation?***

It is lengthening spectacularly. Fifty years ago the average American could not expect to live past forty-eight. Today the average life expectancy is about seventy, and in the year 2000, it will be eighty-two. These figures, of course, reflect the decline in infant mortality. But life expectancy for the aging is improving regardless of factors that bring up the general average. In 1900, a sixty-five-year-old male could expect to live only eleven and a half more years, a female, twelve years and two months. In 1960, the men in this age group could expect to live another thirteen years, and the women, fifteen and a half years.

With continuing scientific advances in eradicating infection, preventing cancer, and controlling the degenerative diseases, it is predicted that by the end of the century life expectancy may approach one hundred and twenty years.

***Is the tendency to long life inherited?***

The everyday sayings, "I come from a long-lived family," or "The best way to insure yourself a long life is to choose your ancestors wisely," have a sound basis. Studies reveal overwhelmingly that the tendency to long life is inherited.

***Is the attitude of the community changing toward the aged?***

The community is beginning to recognize the special needs of a formerly overlooked group. As recently as fifteen to twenty years ago, few beside social workers and philanthropic groups, usually denominational, gave any heed to the older person's need for "somewhere to live, something to do, someone to care," as the Quakers put it.

Now, increasingly, communities have recreational facilities for the aged such as Golden Age centers and hobby shows. They provide services like Friendly Visitors, Visiting Homemakers, and meals-on-wheels, which enable old people to live in their homes. Some employment services and some medical centers give specialized attention to older men and women. The community is more alert to the necessity for licensing and supervising nursing homes than it was when most states gave the sick aged less protection than the patrons of saloons. Public housing is no longer geared exclusively to the young: the number of units designed especially for those over sixty-five is increasing; so are the retirement hotels and villages, both commercial and non-profit. Although community facilities for the aged are still woefully inade-

quate, and old people are not sufficiently integrated into community life, at least their existence is now recognized. Indeed, they are often referred to as a "community problem."

Some of the awareness of the aged and their needs has been stimulated by the efforts of a handful of forward-looking, dedicated persons. Some is the effect of senior citizens' organizations that vociferously make themselves heard—and use their votes. Perhaps most of the awareness is the result of the "population explosion" of aged men and women who, with the rapid increase in their number, seem suddenly to be about. One aged person in twelve of the total population, one in every seven adults, means there are more than twice the proportion of aged people than there were in 1900.

*Is there less respect for the aged now than there was in previous generations?*

While an occasional old person may get great respect from the community and have influence in it, there probably is less community respect for the aged, now, than there used to be. For one thing, elderly people are no longer rare and precious, as when relatively few of them survived. Nor are they as useful as they were in simpler, rural civilizations, where their experience and skills commanded deference. Modern industry puts a premium on quickness and energy, qualities which decrease with aging. Youth is catered to and glamorized with a consequent downgrading of age.

*Is the attitude of the family and the individual changing toward the aged? Is there less homage given the aged relative than in previous generations?*

Not as much as is generally thought, sociological studies indicate. Many persons idealize the family of the past as embracing aged parents and aunts and uncles and grandparents, in contrast to the father-mother-children family unit usual today. Actually, the latter type of family was quite well established in the nineteenth century and most of today's old people grew up in it.

Another prevalent popular idea is that grown sons and daughters do not love their aging parents as much as aging parents were loved in previous generations; that they selfishly "get rid" of them by "dumping" them in nursing homes and mental hospitals, whereas in the past, feeble, forgetful old people were tenderly cared for in their children's homes. As a matter of statistical fact, about the same pro-



portion of old people in the population live with their children as did one hundred years ago.

Attitudes involving parents originate in childhood and, basically, are probably not too different from what they always were. It is circumstances and practicalities that are changing. The cool hand of a loving daughter on an ailing white-haired mother's brow, for example, is no substitute for modern nursing skills, and paying for care in a nursing home may represent just as much devotion and sacrifice as taking Mother in. A city apartment or a small suburban ranch house cannot accommodate the aged in the same way as a sizable frame house with several stories and a veranda. Married women out working—usually because they badly need the money—cannot be on guard lest Grandpa forget to turn off the gas.

Less homage is apparently given to aged relatives than in previous generations. Again, this may not evidence a change in basic attitude as much as in customs, for "Honor thy father and thy mother" goes deep in almost everyone's fundamental emotions. Formerly if a young person was not "obedient to elders" or failed to "show respect," he let himself in for punishment. Present-day families are not required to sit silent while Grandpa is pronouncing words of wisdom: indeed, with the acceleration of technological and scientific changes, he is more likely to be looked on as an old dodo, who, if he wants to learn something, ought to listen to the others. Withal, nearly 2,300 retirees surveyed in a Cornell University study considered their relationships with their children satisfactory, and 92 per cent specified that they believe their children respect them as much as they should.

*Why do so many people feel so strongly negative about the marriage of an aging person? Are elderly marriages foolish or improper?*

One reason is the cult of youth. Romance is supposed to be a monopoly of the young, and there is a long-standing notion that it is somehow disgusting for an aging person to be attracted by the opposite sex.

Grown children often object to the remarriage of a parent for additional reasons. They may feel that it is disrespectful to the memory of the parent who is gone, regardless of the fact that no higher compliment can be paid to a deceased spouse than that marriage was so satisfactory an experience it bears repetition. Or a son or daughter may have the image "My Mother" or "My Father," with accent on "My," and so be shocked and repelled by the image of the parent as

an independent person with a full life of his or her own. Some adult children, in a concealed way or openly, fear that inherited money will not come to them, especially when a prospective stepmother is young enough to start a second family. On the other hand, if an elderly parent's second spouse is also elderly, the children may be afraid that someday they might have two decrepit persons on their hands.

A foolish or improper marriage is foolish or improper at any age, and similarly at any age one that is good and desirable remains good and desirable. Congeniality, companionship, the desire for one's own home, financial security, and sheer relief from loneliness, in addition to sexual desire or even where there is little or none of it, are all valid reasons for marriage in later life.

*Has the moderate financial security now so prevalent (through social security benefits and retirement plans) affected the aged in their feelings about themselves? Has this financial security affected the quality of their feelings about others?*

They enjoy the greater self-respect that comes with knowing that their income is a right that has been earned rather than a charitable handout. Although social security payments are often inadequate and support them meagerly or only partly, they have some sense of independence impossible for the penniless. Studies have shown that most old people prefer not to live with their children, even if they would have greater material comfort in their children's homes than in their own.

*What is the nature of the hostile or guilt feelings that arise when the aged person becomes a severe financial burden to his children or other relatives?*

These feelings are the product of anxiety. During childhood, a parent or another adult relative stood for all that was strong and knowledgeable. When the parent or relative becomes helpless and incapacitated, it is frightening, and makes the child—now an adult—feel helpless too. Once he depended upon them. Now they depend upon him, and this makes him anxious as it would have during childhood. Nobody enjoys being anxious. The upset son or daughter becomes hostile to the aged person who has let him down by being dependent, and sometimes he wishes the parent would die rather than continue to be a financial burden. Guilt feelings result, and more hostility, also directed toward himself for having such evil, ungrateful

thoughts. Such guilt feelings may be covered up with overprotectiveness and an exaggerated sense of concern for the older person.

When a mother about seventy is hospitalized, and her daughter is about fifty-five or fifty or even in her late forties, says Maurice Linden of the Philadelphia Department of Health, the situation is especially fraught with psychological stress. Middle age is a period with declines and anxieties of its own, "and the addition of new guilt feelings can very readily lead to depression."

Another cause of anxiety is the uncomfortable reminder that the son or daughter now having a dependent aged parent may someday become one himself, and that his behavior will help shape that of his children toward him. A Mexican legend perfectly illustrates this point. When Juan no longer wanted to be burdened with his father, he told his son to conduct the old man to a faraway mountain. "But so he will have some comfort, be sure to leave with him a little food and a blanket," Juan said. The son returned carrying half a blanket. "Why do you bring that back?" Juan inquired. And the youth answered, "I am saving it for you."

*What attitudes make it easier for the aged person to enjoy social activities?*

Attitudes similar to those that a person of any age needs to enjoy social life, only a little more so. An older person has to be especially careful not to carry chips on his shoulder, and should be willing to go three-quarters of the way in meeting people. He must not give way to "I'm done for" or "What's the use?" or "Who wants me around?" feelings that retirement or physical disability may have brought about. He must try not to be self-centered, and should avoid attempting to hold the floor with long drawn-out stories in general, reports of his physical ailments in particular.

It is not so hard to make friends in the later years as it is to make the effort to make friends. Social life does not come as easily and as naturally to aged persons as it does to the young, through their schools, jobs, Parent Teacher associations and church activities, and older people must search for their own channels of social activity.

Many older persons find that clubs, centers, and organizations exclusively for the over-sixty-fives facilitate social life. They are less diffident in associating with their contemporaries than in attempting to mingle, as some put it, where "I'm not wanted." Such aging persons should have an exploring attitude, especially if they move to a new

community, and make it their business to find out what is offered for their age group, and where.

Other older persons do not wish to restrict themselves to mingling with contemporaries. If an aging person wishes to have younger friends, he must not expect deference from them and he must be satisfied to be on the giving, more than the taking, end of the friendship. It is a bitter fact, in our culture, that he needs the younger people more than they need him, but if accepted and he is alert and interesting, the sweets of at least some youthful contacts can be enjoyed.

Recent studies have shown, however, that an old person need not necessarily lead an active social life in order to be well adjusted and relatively happy. Especially in very late old age some individuals are serene in the enjoyment of a contemplative, solitary way of life.

*Efforts are being made in some quarters to provide the aged (after compulsory retirement) with jobs that are often far simpler and lower paying than were their lifetime jobs. Are these efforts based on sound theories of mental health?*

Sometimes they are not. Much depends on the individual—his mental and physical vigor, the type of work he has been doing, the demands it has made on him, and his capacity for continuing to meet those demands or perhaps even greater ones.

But often the efforts to find easier jobs for the aged are realistic, and in such cases the answer to the above question is yes. Not only does our economy discriminate against the older worker, but also the pace and strain of work engaged in previously may be inadvisable now. Since studies have shown that paid work improves the morale of retirees, it seems better that they have some jobs rather than none. Quite aside from earnings, it is also likely to be beneficial for someone to continue in his accustomed sphere of work, even if in a lesser capacity. Mental health is furthered if the placement service makes it part of its business to help the aging, when practical and advisable, to accept and adjust to simpler and lower paying jobs than the ones they held during their pre-retirement life. The adaptation they may need to make is not dissimilar to the adaptations they have had to make in connection with other pursuits, such as giving up strenuous sports.

*Is there any inherited tendency in the mental disorders of the aging?*

Inherited tendencies may be among the many factors that play a significant part in the mental disorders of the aging.

***What is "second childhood"? How does it manifest itself?***

This is an unfortunate expression. There can no more be a second childhood in the life cycle than there can be a second puberty or young manhood. An aged person has had too much wealth of experience to be considered identical with a child. What is popularly meant by second childhood is technically known as regression (a going back). The aged person displays behavior that has a superficial resemblance to the behavior of early childhood. Since younger psychotics sometimes likewise regress, it is possible that an element in such behavior may be an escape from the reality that is intolerable. What is known but little understood is that regression is the result of severe organic impairment.

Regressed old people may play with toys, whimper, pout, and in general act heedlessly. They lack judgment. As children do, they love to hoard worthless objects. The regular cleanup in the geriatric ward of all good mental hospitals is a source of anguish to regressed patients, but it has to be done for the sake of sanitation and the reduction of fire hazards.

Some old people refuse to eat, as a bid for attention, and must be spoon-fed. But others who must be spoon-fed have lost the coordination to feed themselves. Similarly in some cases incontinence (wetting and soiling) is a bid for attention and is correctable with training. In many cases, however, it is due to sheer loss of bodily control and is in no way the old person's fault.

***Why do some aged persons become vindictive, greedy, nosy, or mean, when this behavior is unlike that of their previous years?***

Such persons always had these unpleasant traits, but when they were younger they had the emotional strength and the motivation to hold them in check. They might have lost spouses, jobs, and friends had they given way to these traits. When they no longer are, or need be, concerned with the impression they make, their controls are gone with the wind. Former president of the American Psychiatric Association, Arthur P. Noyes, has remarked, "The older a man grows, the more like himself he becomes."

***Why do some aging persons display increasing repetitiveness in certain habitual actions and movements?***

Repetitive movements such as floor-pacing, hand-wringing, or foot-tapping, may serve to reduce tension at any age. With older persons,

repetitiveness may simply be comfortable. They have so much difficulty in forming new ideas and habits that it gives them reassurance to continue "in the groove." Tedious repetition of oft-told tales may be associated with memory loss or an old person's wanting to make himself noticed.

*What accounts for the fact that some aging persons forget their own names and addresses, even such facts as how many children they have had, or other vital family facts?*

This is a result of confusion, which goes hand in hand with memory loss. When memory loss is this severe, it cannot be considered part of the normal aging process. Perhaps not enough oxygen is reaching the brain because of arteriosclerosis, or there may be an acute infection or toxicity, or metabolic disturbance because of malnutrition, disease, or chronic brain deterioration as in senile psychosis. The aged person's psychological state, long-standing or present at the time marked loss of memory begins, may contribute to the condition.

*Why do some older persons wander off from home, or get up in the middle of the night and go out into the street?*

According to Ewald Busse, Duke University Medical School, in the aged, a desire to wander is the equivalent of "wanderlust," the German expression for the normal yen to travel. Just as most of us enjoy the opportunity to get away from problems and at the same time experience new excitement which we can report to someone else so, in the old person, wanderlust takes the form of just wandering or walking about the neighborhood. "When the wanderlust appears in an old person," Busse writes, "it indicates that certain things have not been adequately supplied to him. He feels that he has no significant role in his home environment and that he is not getting the new experiences in that setting that he requires. The person wandering about does not really know what he is looking for but must do something to reduce tension even though little will be accomplished by walking or driving around."

Also, wandering may be the product of just plain confusion. Cerebral arteriosclerotics have a tendency to reverse day and night; they sleep by day and tend to wander by night. Sometimes an aged mentally disordered individual on the go does not know where or why he or she is going. Others have an idea as to where they want to go but not how to get there and wander somewhere else.

***Why are habits of personal cleanliness and tidiness sometimes abandoned where there seems no bodily enfeeblement to account for such behavior?***

Unsavory personal habits may be part of regression: general impairment of judgment prevents a person from realizing what he looks and smells like. Old people chill easily and their skin is dry with the result that many find bathing uncomfortable. The sense of rejection by the community or family, and a feeling of depression, may give rise to the conscious reaction, "What does it matter what I look like?" or the unconscious one of giving others a really good reason for rejection. Many elderly persons grew up at a time and in surroundings where frequent baths were not taken and they revert to the habits of their childhood. Also, even though there may be no apparent bodily enfeeblement to account for a change in standards of cleanliness, energy and strength are limited, and taking a bath or shower may simply not seem worth the effort required.

***Are there explanations for the commission of sexual offenses or sexual display by older persons with no history of such behavior?***

Regression and impaired judgment involve the inability to distinguish right from wrong. The controls developed over the years are as weak or absent as those of a young child. Disturbed by impotence, unable to have sexual relations with his wife, a regressed elderly man may indiscriminately seek other means of sexual satisfaction, such as displaying his genitals, or seek unsophisticated objects of his need, such as children. Some do not differentiate between little boys and little girls just as very young children in their sex play do not either. The moral breakdown that occurs with brain deterioration may occur in a man who is still potent, but whose wife is uninterested in sex, or dead, and when he cannot find an adult woman as a sexual partner. Sometimes old men considered to be deliberately displaying their genitals before children merely want to urinate, but are too regressed to consider when and where.

***Are these mental disorders more common to aging men than to aging women?***

As reported, they certainly seem to be. More indignation is aroused by men's sexual aberrations than by women's. The homosexual man, for example, is much more the target of public indignation than is the homosexual woman. The police, reflecting community attitudes,

are readier to arrest an older man who seduces a young girl than an older woman who seduces a young boy.

But even with the distortion caused by such attitudes, and in the absence of comparative statistics, probably there still are more aging male sexual offenders than female, according to Benjamin Karpman, an authority on sexual offenders. In our culture, he finds, women are more repressed sexually than men. Therefore, they tend to satisfy sexual drives more through masturbation than through offenses against others.

*Do some aged persons with mental disorders become dangerous to themselves?*

Definitely. One of the least spectacular but greatest dangers is starvation or semi-starvation. Large numbers of the aged persons admitted to mental hospitals are seriously undernourished. Often poverty is the cause. But even where there is enough money to buy the right kind of food, a disorganized, confused, perhaps physically infirm old person is unlikely to make the effort to get it, prepare adequate meals or, indeed, even realize when it is time to eat.

Wanderers may be oblivious to the hazards of city or highway traffic. Forgetful, confused old men and women neglect to turn off the gas, to run cold water with the hot, or to lock doors in delinquency-infested neighborhoods. Such incapacity to assume everyday responsibility can also be dangerous to others, especially if the older person is left in charge of children.

If, like psychotics of any age, an elderly mentally disordered person has delusions (fixed ideas unrelated to reality), he may do harm to someone he mistakes as an enemy or take appalling chances at the command of his "voices."

*Do some aged persons with mental disorders become dangerous to others, particularly children?*

The danger that senile sexual offenders present to children has been greatly exaggerated. As a rule, the damage to children exposed to the aberrations of old men has resulted more from the way the episode was dealt with by parents and in court than from anything directly hurtful to the child. A common sex offense among aging regressed men is exhibitionism, that is, displaying the genitals. Rarely do exhibitionists make any move for direct contact. When parents, police, and the community calmly take the attitude about exhibitionism or



fondling such as—"the poor old man is sick, pay no attention, we'll try to see that he doesn't do it again,"—the child comes off better emotionally than when she has to tell the story over and over again to her parents, the police, a court, and perhaps others, or is treated at either extreme such as "bad" or "a poor, poor abused darling." In the study made by Kinsey, women who, during their childhood, had had sexual advances made to them by older men, reported little psychic damage unless a great to-do had been made of the incident.

***Is the rate of suicide of the aging different from the rate of suicide of the population in general?***

In all countries where suicidal rates have been studied, there is a peak that shows up in late-middle age or old age. Awareness of mental and physical decline, loneliness, forced idleness, inability to adapt to changes in the conditions of life, and incurable disease probably account for this more often than psychosis.

***Can an aged person "lose the will to live" and so die?***

Yes. Doctors and nurses who care for the aged in institutions often express surprise at how tenaciously most of them cling to life even in the face of incurable illness and no family ties. But occasionally someone, often a person in relatively good health, feels that life has nothing more to offer. The wish to die, in younger people, may or may not be granted, for the body fights back. When an aged person loses the will to live, however, death comes with astounding rapidity. Science has no explanation for this.

***Why do some aged persons seem to turn on the very person who is giving them the most attention and affection and care—and so make life miserable for this person?***

Such reactions are sometimes combined with organic losses, especially of hearing and vision, but, according to Busse, are rooted in the insecurity, loneliness, fears, and unfulfilled wishes of old people. Usually they occur in an aging person who for some time has been suspicious, and inclined to blame others for his failures. When with advancing age his social and financial situation changes, he does not look on the decline realistically but interprets it as failure. He feels that the younger people around him are responsible for this. They are jealous of his own superior endowments and abilities, and spitefully prevented his using them. The solicitous care he gets may be distorted

as an envious attempt to keep him down, and tenderness may be misinterpreted as a cover-up for evil designs to prevent him from having the place in the world that he warrants. Therefore, the person who gives him the most attention is the one who most arouses his suspicion and hostility.

*What are the tensions, and what are the rewards, for the aging living in a three-generation household with children or other relatives?*

Each individual and each family is so different that no generalization can apply to all three-generation households. However, studies have shown that old people stay healthier and live longer when they maintain their own homes, and that the great majority of them prefer not to live with their children. Loss of independence and some inevitable loss of privacy underlie most of their tensions.

A person who has established ways of doing things over many years has to adapt to the ways and routines of the new home. An older woman, especially, often finds it hard not to be its mistress. The tension is likely to be greatest when the oldest and the middle generations have different social and economic standards, for instance, rural versus urban, or a former unskilled laborer versus a successful businessman or professional man. Food, conversation, family activities, and the community may seem alien. Particular difficulties tend to occur if the older persons were immigrants and lean toward old-country ways: they are likely not to feel "at home" at home. If the age gap between the oldest and middle generation is very great, tensions tend to be intensified.

Often the oldest generation is troubled by "the way the children are brought up." The grandchildren, who were sheer delight when seen occasionally, may be disturbing because of their noisiness, mishaps, and misbehavior. Adolescents in the household are likely to be particularly trying to resident grandparents.

Even if the younger generations are devoted and considerate, the old person in the household may have a miserable sense of not belonging. In our culture the family does not automatically incorporate the aged nor define their place in it. As soon as children leave the parental home, and especially when they marry, they become a separate family unit. When an aged person's grown children entertain friends, for example, he may be troubled as to his role. Should he join in their conversation and parties (which may not even be congenial to him)? If he does, will his children and their friends feel they can

be themselves? If he does not, might he hurt the feelings of the younger persons on whom he is dependent? If he, or more likely she, offers to help in the household, might it be taken as implicit criticism? Without helping, is he or she a "burden"?

On the other hand, for some persons the rewards of living in a three-generation household outweigh the tensions. Someone who has had a lifelong tendency to be dependent may enjoy the security and comfort it affords. Where a grandparent is really needed—for instance, if a parent is dead or a mother is working—there can be great rewards in feeling still wanted and useful. And, although the aged do not enjoy "living through their children" nearly so much as most younger persons fancy, granted a right to their own identity, interests, and pursuits, they may enjoy a heartening sense of participation in vigorous, ongoing life.

*What are the possible effects on the aged of living in apartment communities specifically for the aged, or homes for well people who are elderly?*

Although in each of these living situations old people live among others of their age group, essentially the situations are different. The residents of an apartment community are independent, and free to come and go and set their time schedules as they please. At the same time they have readily available companionship and social life without the strain of trying to keep up with others who have much more energy than they. Where the apartment community is near enough the community at large for the elderly to venture forth into it, they can have the contacts with young people and children that they may want, yet are spared the annoyances of tripping over tricycles in hallways or children's noisiness. Usually the effects of living in an apartment community for the aged are desirable.

Residence in a home for the aged always involves renunciation of full personal independence. For some persons the sense of security and protection may make up for this loss. Generally, however, the longer an old person remains on his own the better. The better homes for the aged do everything possible to prevent residents from sinking into apathy, depression, and greater dependence. They have excellent activity programs and a minimum of rules and regulations and protectiveness. They respect the individual's need for privacy and they encourage him to have community contacts.

But in too many homes for the aged there is stagnation. Buildings

which are hangovers of another day enforce isolation; either they are likely to be far from the mainstream of community life or in old areas deteriorated into slums, into which residents dare not go. Institutional furnishing may deprive residents of the personal possessions that mean so much to old people. Where there are not single rooms, old people are also stripped of privacy. Where there is a lack of programs to stimulate social activity, there is little of it. Large rooms for sitting and social activity have long been the order of the day but, by and large, these are empty or nearly empty at almost any hour. Rigid rules about such matters as the time of rising and retiring, to just what level the shades must be pulled, in what weather residents may not go outside, or when they may and may not have visitors, heighten feelings of dependence. In general, the effects of living in the run-of-the-mill home for the aged are liable to be undesirable.

*Is it likely to be frightening or disturbing to the aged to leave familiar living quarters behind, and move, late in life?*

Much depends on whether the individual was always someone who liked to move about or one who disliked change, but in general, no. This is so in spite of the fact that mortality statistics among patients sixty-five and over admitted for the first time to public mental hospitals are shocking, and sometimes interpreted as an affirmative answer to this question. In 30 of 35 states reporting, 30 to 60 per cent of such patients survived less than a year after admission; in 20 of 35 states, 20 to 40 per cent died within three months. But these pitiful old people are special cases. Many arrive at the hospital in a serious state of malnutrition. Many are ill physically. Some are in advanced stages of senility or arteriosclerosis. Because of confusion and delusions it is difficult if not impossible for them to adapt to new surroundings. Compounding all this may be the emotional devastation of feeling rejected by their children, and the shock and stigma that they are considered "insane."

Most aging persons adjust quite well to new living quarters. Usually, even with initial protest or upset at being placed in a home for the aged, they soon settle down, often more happily than in the place they lived before. Many get a new lease on life when they pull up their roots and start fresh in a new community. Thousands of vigorous, busy senior citizens, who have transplanted themselves to "the retirement states"—Arizona, California, and Florida—far from being frightened or disturbed by the change, are stimulated by it.

***How can relatives tell whether an aged person, suffering from the difficulties of advanced age or a mental disorder, should be cared for at home, in a nursing home, or in a mental hospital?***

There can be no blanket criterion. Placement in a nursing home or mental hospital should always be determined by a combination of family and social circumstances and medical or psychiatric diagnosis. If the aged person lives in a relative's home, each family must ask and answer for itself these questions:

"If he needs constant care, are we able personally to give it, or pay for it at home?"

"Is home care adequate, or might he be helped by skilled nursing and psychiatric care?"

"Will continuity of care be better assured in an institution? Suppose one of us got sick—suppose the nurse or companion or maid quits?"

"What works out best budget-wise?"

"Is my aged relative dangerous to himself or to others in the household?"

"Does his presence seriously interfere with our family life—for instance, our teen-agers' parties?"

"Would his heart be broken if we removed him from our home? Or does he feel that he is a burden to us and would he welcome removal to an environment especially created for people like himself? Is he really happy among younger, more vigorous persons?"

"How do his needs balance with the needs of our family as a whole?"

If the aged person is living in his own home, the decision should be made on the basis of the answers to these questions:

"Does he relish independence? Do the values of his continuing to live on his own outweigh those of his living in a physically protective environment?"

"Might he be able to continue to maintain his own household with some help, such as visiting nurse service, homemaker service, or frequent visits and help in housecleaning and cooking from younger members of the family?"

"Is he dangerous to himself because almost continuously he does not know who or where he is or does not eat, wash, or pay attention to bodily functions, or dangerous to others because of extreme absent-mindedness or delusions?"

Whether the move being considered is from the aged person's own home or from a relative's, the quality of the nursing home or mental hospital to which he would be moved should influence a family's

decision. Some such institutions give nothing more than physical care, and often even that is not good. Others offer excellent programs of treatment and rehabilitation.

*What agencies and individuals are there in the community to help relatives to decide whether to keep an aged person at home or to place him elsewhere?*

Relatives can get medical advice from a general practitioner, psychiatrist, or internist through referral by county medical societies. Family Service agencies and mental health associations and clinics have social workers on their staffs who are skilled in helping clients to size up their family situations, clarify their feelings, and come to their own decisions. The social workers in Public Welfare departments, experienced in dealing with people in difficult circumstances, can also be helpful. The local Public Health Department and the Visiting Nurse Association have nurses who often know the nursing home and hospital facilities of the community. A church, especially one whose clergyman has had training in the relationship between religion and mental health, can be a bulwark against guilt feelings of troubled relatives wondering what is the "right" thing to do, and a source of strength whichever the decision.

*Is psychiatric treatment ever recommended for minor maladjustments in the aged person?*

Yes. Minor maladjustments in the aging are often mistaken for the onset of senility. Often when they are corrected in time through psychotherapy, senility never occurs. When there is no brain deterioration, and sometimes even if there is, buried emotions can be helpfully brought to light and attitudes altered. Several specialists report great success with group psychotherapy with the aging. In the comfortable, reassuring company of their contemporaries, aged people are able to talk freely about themselves and one another and gain insight into their problems.

*Can psychoanalysis be useful for elderly neurotics?*

Formerly it was thought not. Sigmund Freud himself believed that an old person was too set to change, and that the mass of material accumulated in his mind during his many years of life was so great that the time needed to work through it would be virtually intermi-

nable. Of recent years, however, psychoanalysts have reported good results with elderly patients. The usefulness of this particular form of psychotherapy nevertheless is limited because it is too expensive for most elderly persons and because psychoanalysts can carry only a few patients in any given period.

***If an aged person suffers a "mental breakdown," is he incurable?***

Not necessarily. With therapy, about a third of persons sixty-five or older may be expected largely to recover, about a third to get vastly better, and about a third to show little or no change or get worse and probably to die in the hospital. These expectations of response to therapy are practically the same as those for other age groups.

***Are there many cases where an elderly person sent to a mental hospital recovers and is sent home?***

The answer to this question is difficult to pinpoint. Many patients of all ages are released—that is, not discharged, but still carried "on the books" of the hospital—without having really "recovered." Sometimes this is because they have improved sufficiently not to need hospitalization any longer, sometimes because living outside the hospital is therapeutic, and sometimes, where the elderly are concerned, to free overburdened staff to concentrate on younger patients whose cases are considered more hopeful.

A relatively small proportion of the elderly patients in mental hospitals is released. Some of those who are released—in six states more than half—go to nursing and foster homes. But in most of the thirty-five states reporting on the matter, by far the greater proportion of released older patients return to their own homes.

***What are some of the important treatments for the mental disorders associated with aging?***

Although perhaps with some adaptation and a different emphasis, the treatments for the aging are the same as for mental disorders at any age.

Particular attention is given to building up elderly patients' physical health. Often these patients enter a hospital suffering from a combination of malnutrition and inactivity. A proper diet is vital. Many disturbed aged improve so quickly in a hospital that in addition to good nursing and an environment which is psychologically harmless,

eating better seems to be the main agent of healing. Good general medical care and minor surgery to reduce discomfort may improve the mental outlook of an old person even more than they may that of a younger patient.

A kindly, permissive atmosphere, in which the aged person's foibles, eccentricities, and incompetencies are uncritically accepted and in which he does not have to compete with the young, lays the groundwork for resocialization—a regained interest in others and participation in a group. Some elderly patients get great therapeutic benefit from volunteering to help care for patients more infirm than they.

Psychotherapy, individual or group, is a very important form of treatment. Electroconvulsive therapy has been found useful in treating depressions and psychoses in even quite old patients. Where there is brain tumor, the treatment is surgical. Chemotherapy (treatment with drugs) includes antibiotics when the mental disorder is caused by infection, and tranquilizing and antidepressant drugs, some of which improve circulation to the brain.

Activity therapy geared to aged patients' capacities aims at stimulating minds and bodies and encouraging social activity. Among its many forms are recreational therapy, music therapy, and occupational therapy. Even passive recreation like entertainment may be therapeutic by sparking imagination or arousing dulled interests. Some hospitals feature mixed social dancing in their geriatric service. Many older patients flatly refuse to embark on crafts new to them, but skilled occupational therapists help others to achieve a mentally healthful sense of accomplishment and renewed self-confidence.

*Is there an average duration of senile psychoses? Does it steadily worsen? Is there any pattern for the running of its course?*

There is no meaningful average duration of senile psychosis, which continues for the rest of the patient's life. Patients become senile at different ages, and how long they live depends largely on the physical treatment and care they get. The disease steadily worsens. Its pattern is one of gradual and progressive deterioration.

*If someone lives long enough, is he bound to become senile?*

No. Persons may reach such advanced ages as the upper nineties or even one-hundred-plus, yet never exhibit the symptoms associated with a senile psychosis.



# ALCOHOLISM

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## ***What is alcoholism?***

There is no simple definition of alcoholism. For practical purposes, alcoholism may be defined as a chronic, progressive, psychobiological disorder characterized by (a) compulsion to drink alcoholic beverages excessively even though the drinking is harmful to the individual; (b) some degree of loss of control of drinking; (c) deterioration of the person's competence in mental, emotional, physical, family, job, or social areas; (d) use of alcohol as a means of handling serious personal problems.

Alcoholism is not static but becomes progressively worse. The alcoholic's drinking is a symptom of uncontrollable forces inherent in his illness. His drinking is not the result of simple indulgence or weak will and the problem cannot be solved merely by changing his habits; it is a pattern of behavior based upon deep psychological (and possibly also metabolic) needs.

## ***How many alcoholics are there in the United States?***

There are no direct statistics as to the number of alcoholics in the United States; however, E. M. Jellinek's estimation formula, a study on alcoholism, suggests that approximately 4,500,000 people in the United States are problem drinkers, that is, persons suffering from major difficulties associated with their use of alcohol.

## ***What are the distinctions between the moderate drinker, the heavy drinker, and the alcoholic?***

The moderate drinker is a person who uses alcohol only for a mild lift, relief of fatigue, and as an adjunct to social relations. Moderation excludes any use of alcohol for a "jolt" or to get "high" or "tight."

The heavy drinker, however, drinks to the point of being "high," although he may have a considerable tolerance to quite large amounts of alcohol. A heavy drinker may from time to time get drunk. Heavy drinkers are distinguished from alcoholics in that the former appear to have control over their intake although they may become dependent upon alcohol in the sense that they would be uncomfortable without it.

Alcoholics are distinguished by their inability to control the amount they drink or the drinking occasion. The control may be so defective that even one drink will always lead to a "drunk." Other alcoholics find they can "nip along" for several days or weeks before they lose control. The loss of control may be such that the victim cannot withstand the first drink even though he knows it will lead to a "spree" with all the attendant suffering. In the case of the alcoholic, the drinking problem rarely remains static. The illness has a progressive course in which more and more serious loss of control (with "benders" and sprees) and more and more grave psychological, physical, social, and family problems supervene.

*Can drinking, in certain circumstances, be beneficial to a moderate drinker—socially, psychologically, or physiologically?*

This is a highly controversial question about which many able and thoughtful people hold differing opinions. The use of alcoholic beverages medically is becoming less common, and yet many physicians believe that, especially for older people, a drink in the evening or with meals promotes well-being, better appetite, and sound sleep. It seems certain now that alcohol does not have any specifically vasodilator effect upon diseased coronary vessels, but alcohol may be prescribed for those who have had coronary attacks. Its value here is chiefly as a mild tranquilizer acting to allay anxiety. The physiological benefits of alcohol, if any, are probably minimal. Nevertheless, many moderate drinkers feel that they enjoy a social drink for the promotion of fellowship that ensues. Probably the chief benefit of alcoholic beverages—used moderately—lies in the mild relief of tension.

*Is the rate of alcoholism rising?*

At present, the most reliable evidence indicates that since World War II the rate of alcoholism, although it does fluctuate, has remained relatively stable.

***Is alcoholism affecting new or different groups? Women? The young?***

It appears that alcoholism is becoming more widespread in our culture. It is by no means limited to any particular group, such as "skid row" outcasts, but is reported among church members, members of professions, successful businessmen, etc. This may trace partly to the fact that today people are not afraid to admit they are alcoholics and are asking for help and being identified.

It is difficult to know just what the rate of alcoholism is for women. There are said to be about five alcoholic men to one alcoholic woman in the United States. Probably the true ratio is in the direction of a higher proportion of women than this estimate indicates. As women's status in American society becomes more like that of men, the proportion of female alcoholics will probably become more comparable to that of male alcoholics.

In the public voluntary clinics, one receives more and more requests for help from alcoholics under twenty years of age. Probably these young people are more willing to come for help than were such young alcoholics a few years ago. Still, it does appear that the actual number of teen-age alcoholics is increasing. There have been reports of even younger victims in France, where serious symptoms of alcoholic withdrawal have been found in children who had a heavy wine intake.

***Is alcoholism primarily a physical or a psychological problem?***

Probably both. Certainly, the alcoholic *has* physical, psychological, social, family, job, and other problems. As to the *underlying* causes of his alcoholism, it seems probable that there are a complex of metabolic, social, and psychological factors.

***Is there a type of person who seems to tend toward alcoholism?***

The search for an "alcoholic type" has not yet uncovered any psychological or physiological characteristics that are exclusively applicable to alcoholics. In common with nonalcoholics, many alcoholics show such characteristics as dependence, immaturity, psychosexual problems, and vulnerability to tension and anxiety.

***Is the tendency toward alcoholism inherited?***

This has not been proved although it has been advanced as a theory. It has been hypothesized that because of some inherited metabolic defect—as in the body's enzymes or vitamin metabolism—certain

people are more likely than others to become alcoholics. Recent animal studies show genetic differences in the capacity of some animals to utilize alcohol in the body.

The genetic theory of alcoholism suggests several important research problems. One of these problems is to investigate in animals of different genetic strains whether there are differences in the animals' capacity to tolerate alcohol safely. In these animals it would also be important to correlate differences in genetic strains with the animals' preference for alcohol or other liquids and with the concentration in the animals' bodies of alcohol-metabolizing enzymes. If such enzymes should show greater activity levels in alcohol-tolerant genetic strains of animals, these enzymes might be administered to human alcoholics therapeutically.

***Does alcoholism develop at a specific time of life?***

The origins and early stages of alcoholism are to be found in youth (and even childhood), and many alcoholics in their teens and twenties now seek help. In public clinics, alcoholics from teens to late sixties or even seventies are found. The most frequent age of alcoholics seeking help in public clinics is from thirty-five to forty-five for men—slightly older for women. Thus these alcoholics are appearing in greatest numbers at the age of maximum productivity and at the period when involutional changes (changes at the time of the menopause in women and the climacteric in men) begin to affect the person. Most of these patients report that they have had trouble with their drinking for about five to ten years.

***Are there certain circumstances that seem to precipitate alcoholism, e.g., grief, failure, unhappiness?***

Almost any event or feeling—pleasant, unpleasant, or just boring—can precipitate drinking by an alcoholic. We are still ignorant of the basic *causes* of alcoholism. Alcoholics are usually depressed, unhappy people and may have become alcoholics in the first place through attempts to relieve their sense of inadequacy and their chronic unhappiness by the use of alcohol.

***Is there a larger percentage of alcoholics in any one economic group?***

Authorities believe that this is not so. Alcoholics are found among rich, poor, and middle-income groups. There are said to be higher

rates of alcoholism in certain occupational groups, e.g., painters, bricklayers, newspapermen, etc. One reason for this may be the irregular character of their jobs with respect to pay, working hours, and level of activity. It is believed by some that newspaper work, for example, by reason of the many crises it presents, is especially stressful to persons who may be vulnerable to alcohol addiction.

Traditional and cultural factors may contribute toward alcoholism in jobs where heavy drinking is a custom.

*Are there any national groups that have a significantly higher rate of alcoholism? If so, which are they and what causes this higher rate?*

Yes. Alcoholism rates are higher, for example, in France and in the United States than they are in Italy. Recent studies show that higher rates are associated with greater public tolerance of drunkenness. Whether or not this is the cause of the higher rates is not certain.

*What effects does alcohol have on the body?*

The effects of alcohol on the body can be considered from the point of view of the immediate effects (over a period of a few hours) of drinking and the long-term effects of several years of alcohol use.

The immediate effects of alcohol are produced mainly through alcohol's action upon the central nervous system. Alcohol depresses important nerve systems in the brain that normally act to excite, inhibit, and control the orderly function of the cerebral cortex. Therefore, the early effects of alcohol are feelings of relaxation, calming of worry and anxiety, release of tension, and dulling of fear for the future. There is often a sense of gaiety and buoyancy and a feeling of being important, on "top of the world," and master of one's situation. Judgment is soon impaired, and there is often an unrealistic overconfidence. As the alcohol level in the blood rises, coordination of movements is interfered with along with sensory functions—seeing, hearing, etc. Finally there is stupor and coma, and the person is "dead drunk." The nervous mechanisms controlling breathing may be so anesthetized that the person dies. Other acute effects of alcohol include increase in urination through an effect on the pituitary gland.

The long-term pathological effects of overuse of alcohol are principally upon the brain and the liver and are due probably to interference with nutrition and metabolism.

***Why do alcoholics seem to require larger and larger amounts of alcohol to obtain only the same amounts of pleasurable effects?***

Up to a point, alcoholics find that their tolerance of alcohol may increase. Alcoholics often say that they used to be able to drink their friends "under the table." As their illness proceeds, they find sometimes that the pleasurable effects become briefer and that although they drink more, this does not necessarily bring greater or more prolonged pleasure. Later they drink just to keep the tremors and delirium away. We do not know why the alcoholics' response to alcohol changes in this way.

***What effect does alcohol have on a person's sexual drive and capacity?***

In some people, certain amounts of alcohol may relieve anxieties and inhibitions in such a way as to increase sexual drive. Some people do use alcohol for this purpose. In general, however, alcohol acts as a sedative; but, although it may increase sexual interest, it tends to reduce sexual performance. Alcoholics report that during their drinking periods they are not able to achieve sexual consummation as they would like. Generally, a drinking alcoholic is an undesirable sexual partner.

***Does alcohol affect one's ability to work effectively?***

This depends upon the pattern of drinking. Used in moderation (not to getting high or tight) alcohol has no effect upon most people's day-to-day work performance. Heavy drinking and alcoholism do, sooner or later, adversely affect the ability to work effectively. Many people do use alcohol to try to keep themselves going at their jobs.

***Does alcohol affect a person's ability to do physical labor?***

In some cultures it was formerly thought that alcohol imparted strength and was necessary for those who did heavy physical labor. In some wine-drinking countries, the idea still prevails: "Wine is a source of strength." There is no scientific evidence that this is true. Alcohol is a source of calories, but is inferior to other foods as a source of energy.

***Does alcohol interfere with the performance of routine mental and manual chores?***

Yes. This depends on the amount taken and the rate at which the alcohol level of the blood is built up, as well as on the personality

of the individual. Some of the earliest effects of alcohol are on judgment, insight, motivation, and attention.

***Why does driving a car become hazardous when a driver has been drinking?***

Mainly because, even after a few drinks, attention wanders, concern for safety and caution tend to be impaired, and judgment becomes faulty. This happens even before impairment of motor coordination and slowing of reflexes. Some people, after drinking, become exceedingly cautious; others take the wheel with grandiose self-confidence. The problem of drinking and driving is complex and difficult because so many people do drive after one or two drinks.

***Can alcohol help to inspire the creative worker?***

Some creative intellectual workers say that a few drinks help them to think better and to produce at a higher level of excellence. To the extent that alcohol may initially overcome anxiety and depressed feelings, it may help a person to get started at a task and to “inspire” him. The trouble is that it also (if he takes enough) fogs his mind, resulting in inferior output.

***Is it true that some writers, artists, poets, and musicians have created successful and even masterly works of art while under the influence of alcohol? If true, why?***

This has been claimed. Certainly many writers, artists, poets, and musicians have been alcoholics. Alcoholism, however, generally is associated with progressive deterioration of artistic production. As to the creation of masterly works while under the influence of alcohol, if this is true it probably has to do with the release of inhibitive factors that prevent the artist from functioning when sober. Most creative writers and artists find that what they write, paint, or compose when really drunk looks or sounds very poor and foolish in the sober light of day.

***Why do some people become surly, belligerent, and cruel when drinking, though agreeable when sober?***

Hostile feelings such as suspicions, paranoid feelings, and jealousies that are suppressed while sober are often released and acted out when drunk. When drunk, a person—through release of inhibitions by alcohol—is more likely to respond impulsively to environmental

stimuli than when he is sober. This does not necessarily mean that alcohol reveals the "true self." It does mean that under the conditions of disturbed cerebral cortical functions caused by alcohol, unresolved feelings, conflicts, and desires may be expressed—usually not in a way that solves them. Thus, the drinking experience does not help a person to grow and mature.

*Why are crimes of violence sometimes committed—under the influence of alcohol—by persons without a background of aggression or criminality?*

The restraints imposed by social consciousness and sensitivity to others' rights and feelings can be overthrown by the influence of alcohol. It should be said, however, that the person who commits a serious crime of violence while under the influence of alcohol is probably an individual whose personality is disturbed even when sober.

*Why do some persons, when drinking, commit an act of marital infidelity that they would probably not have carried through when sober?*

Drinking can arouse sexual desire and numb a person's moral qualms. It seems likely, however, that in cases of marital infidelity drinking is not so much a *cause* of infidelity as an incidental accompaniment.

*What is the cause of alcoholic stupor?*

The alcoholic stupor is caused by widespread anesthesia of brain mechanisms. The person in a stupor or coma is not far from respiratory paralysis and death.

*What is the nature of the loss of memory, during a period of drinking, that afflicts some people?*

Alcoholic stupor is to be differentiated from the "memory blackout," a condition characterized by lapse of memory during a drinking period. The victim walks and talks or even drives a car but later has no memory of what happened. This is a serious sign that alcohol has begun to affect the brain adversely. The memory blackout is caused by the fact that alcohol has selectively anesthetized the brain mechanisms serving the functions of awareness and recall without destroying the capacity to act in response to stimuli.



***Why are pregnant women advised not to drink alcoholic beverages?***

Usually, because it is considered that alcohol in the fetal blood-stream exerts unfavorable physiological effects upon the unborn baby. This problem requires further study.

***Would the mother's drinking have a psychological as well as a physical effect upon the unborn baby?***

Probably not, unless the drinking is grossly excessive, sufficient to cause brain damage. Further investigation of this matter is needed.

***Aside from moral aspects, is alcohol dangerous to children?***

In some cultures, e.g., French, children customarily take wine diluted with water at meals. This practice, even among young children, has prevailed for centuries in France and has been said to be harmless. More recently, it has been asserted that alcohol is bad for children because it deprives the child of nutritional requirements necessary to healthy development.

***Does heavy drinking cause any changes in the body after a time?***

It can. Some individuals appear to drink heavily for many years and are apparently unaffected, but others are not so tolerant of heavy drinking and may show damage, e.g., to brain or liver.

***Are ulcers the result of heavy drinking?***

The causes of peptic ulcers in man are not known. Ulcers can be produced experimentally in dogs by heavy alcohol ingestion, but there is no good evidence that drinking *causes* ulcers in man. People sometimes drink to try to assuage the pain and other symptoms of ulcers, but it is found that drinking may make the condition worse.

***Do some people really get a red nose from excessive drinking over a long period of time?***

Yes, sometimes. This is an effect upon the skin blood vessels and is not well understood.

***Can excessive drinking damage the brain?***

Yes, it can. Probably it is not the effect of the alcohol directly, but rather the action of metabolic and nutritional defects associated with or caused by alcohol.

***Is it true that when a drunken person has an accident, such as a fall or being struck by a car, he is less likely to be injured than if he were sober?***

No. People under the influence of alcohol are very vulnerable to accidents, and drunkenness is a cause of large numbers of cases of accidental injury and death.

***At what point can it be said that a person is no longer a heavy drinker but has become an alcoholic?***

The changeover really comes when the person loses control of his intake. An alcoholic drinks when he does not intend to and drinks more than he plans to. His drinking becomes irresponsible.

***Does association with heavy drinkers cause a person to become an alcoholic?***

Probably not directly. The causes of alcoholism are to be found within the individual himself—psychological and metabolic factors. Social causes are probably operative also, and association with heavy drinkers may trigger off a drinking spree in an alcoholic. For the causes, however, one must look more deeply.

***Does growing up in a family that has a heavy drinker or an alcoholic cause a person to become an alcoholic?***

Growing up in such a family can cause a person to have exaggerated feelings about alcohol. Some people from this type of family become ardent teetotalers. Also, a child of an alcoholic parent may—because of complex factors of identification—seem to imitate the parent and eventually become an alcoholic.

***Does growing up in a family of teetotalers, where drinking is strongly forbidden, cause a person to become an alcoholic?***

It does happen that alcoholics sometimes come from families that have feelings against drinking. It is not known whether such a family actually causes a member to become an alcoholic. It is possible that rebellion against restrictions and lack of warmth and affection may be factors. There is, however, no *a priori* reason why an abstaining family should be more likely to produce alcoholic offspring than should a drinking family.

***Does overwork, and the subsequent effort to relieve tensions, cause alcoholism?***

This sometimes appears to be a cause if one reviews case histories of alcoholics. It is more likely that the person overworks for the same basic causes (compulsions, guilt, etc.) that also lead him to seek relief through the use of alcohol.

***Does the fear of not being able to meet one's obligations and responsibilities cause one to become an alcoholic?***

Feelings of inadequacy are expressed by alcoholics and these feelings are to some extent relieved by drinking. Fear of inadequacy may be a part of the complex combination of causes.

***Is there any physical reason why one person becomes an alcoholic and another, who also drinks, does not? Any psychological reason?***

Specific physical causes of alcoholism (such as metabolic, nutritional, and hormonal factors) have not yet been clearly established. It does seem reasonable that such factors exist. As to psychological reasons, clinical research has not yet brought to light any specific ones. That alcoholism is symptomatic of underlying disturbances (psychological, physical, social, etc.) is likely. There seems to be no *single* cause.

***Does the alcoholic understand that he is a neurotic person, or does he feel he is an entirely normal person who has a bad habit?***

He may not understand. Often, an alcoholic is greatly influenced by the popular attitude that there is nothing wrong with him except that he has acquired the bad habit of drinking to excess. He believes that if he would only use his "willpower," he could either stop or control his drinking as other people do. The fact that his drinking is a compulsion and is out of control is an insight that he experiences usually only after sound psychotherapy. Without help it is difficult, if not impossible, for him to accept and understand that his uncontrolled drinking is symptomatic of psychological, social, and (possibly) metabolic disorders, affecting his life.

***If the alcoholic's drinking handicaps him occupationally and emotionally, and he is aware of this when sober, is it possible that he wishes to handicap himself?***

He probably does not consciously and clearly express a desire to drink to handicap himself. Nevertheless, this is often exactly what hap-

pens. An alcoholic, before therapy, may not ascribe his emotional and occupational handicaps to alcohol. In fact, he may feel that his drinking "keeps him going." In a sense, this may be true. The alcoholic may be using alcohol to try to adjust to tasks for which he does not feel adequate and to attempt to deny and exclude what seem to be insoluble emotional problems. Many alcoholics assert that when they drink they feel important, cared about, and better able to relate to other people. Their shyness and inferiority feelings seem to melt away after a few drinks. Under treatment, some alcoholics gain insight into the fact that they used alcohol to prevent effective dealing with their emotional and other handicaps.

***Could the alcoholic use his handicap to defeat his own ambitions?***

Yes, he could. The effects of alcohol could provide a substitute for whatever achievement is within his capacity. Under the influence of alcohol, the alcoholic may feel that he has already achieved the comfort and happiness that others derive from their daily struggle with the ordinary tasks. The alcoholic often shuts himself off from the wholesome job of planning his life goals in terms of attainable objectives.

***If he were afraid of love, could the alcoholic hide inside his handicap by making himself unlovable?***

Yes. His alcoholism—which would serve to make him an unacceptable person in his family, job, and community—might simply reinforce his own sense that others do not love or appreciate him, that he is different from others, or that he does not fit in. This would drive him further and further into himself—all his misfortunes and other persons' criticisms of his behavior confirming that the world is against him.

***Many alcoholic women and men have young children whom they love. How is it possible for them to continue to drink to excess when they know they harm their children?***

Alcoholics continue to drink to excess even though they see their own health being ruined, their careers turned to dismal failure, their marriages wrecked, and their children deprived of the physical and emotional support they need. Nor are alcoholics unaware of what is happening. Indeed, they suffer from remorse, guilt, confusion, and perplexity. They often ask themselves the same question: "Why do I

do this, knowing it is destroying all that I am and have and bringing shame and misery upon those I love?" If some alcoholics have not asked this question, it is because they must hide from themselves the true situation; but even when they do ask the question, they don't stop drinking. This speaks for the compulsive nature of their behavior. An alcoholic's drinking is so much out of control that responsible drinking is impossible.

***Is the alcoholic generally hardhearted?***

Not any more than anyone else. When drinking, an alcoholic may exhibit emotional extremes. He may be overgenerous, friendly in a superficial, fatuous way, and show poor judgment. Sometimes the spouse of an alcoholic complains that when the alcoholic stopped drinking, his personality seemed to change for the worse; he became hard to live with. This may be true when the alcoholic cannot achieve a happy sobriety. Sometimes such a change in relationship develops because the spouse cannot accept the husband or wife as a growing, maturing person.

***Is the alcoholic generally selfish?***

The alcoholic is probably about as selfish as most people. He is said to be characteristically self-centered, but it is unwise to ascribe any particular personality qualities as typical. If the alcoholic is more self-centered than most people, it may be because he is frequently so anxious and tense and feels so concerned about himself.

***Does the alcoholic drink to excess in order to indulge in behavior he would not approve of when sober?***

Yes, he may. Or, just as likely, he may drink to do things he is afraid to do when sober. There is no question that alcoholics, when they drink, behave inappropriately. Their judgment is impaired, and they often get into trouble. Alcoholics do try to stay out of trouble and frequently they learn to drink under circumstances that they consider safe, for example, in a hotel room.

***Do some alcoholics hide—in drink—their fears about their masculinity?***

Psychological tests carried out on alcoholics reveal that many have an inadequate sense of their own masculinity or show other evidence of psychosexual conflict. It would be a mistake to say, however, that

all people with psychosexual problems become alcoholics or that one of the essential causes of alcoholism is, for example, latent homosexuality.

Some alcoholics are latent or practicing homosexuals, and some may be fearful of their own sexual orientation. Usually, however, such fears are not recognized by the patient; most alcoholics' conscious fears are in other areas.

***Is the alcoholic unable to face realities about himself—such as hatred for a parent or guilt for some wrongdoing?***

Yes. Alcoholics often find it intolerable to face themselves as they actually are. They cannot accept their feelings of hatred, anger, jealousy, and guilt. When faced with undesirable feelings about parents, spouse, or boss, for example, they may get drunk rather than examine their feelings. It is as if they believe that such feelings should be dismissed as wrong—that one should not “feel that way.” Perhaps they fear that such feelings will lead them to impulsive actions they will regret—actions that will increase their guilt and sense of worthlessness.

***What happens to the “cured” alcoholic who has been using drink to hide from himself?***

Alcoholics who really use effective psychotherapy learn to take regular inventory of their lives and when they discover they are wrong, they admit it and, if possible, make amends. This can be called true sobriety. Such a person strives daily to become the kind of person who can live without alcohol. He tries to change the things that he can and should change, to accept as inevitable the things he cannot change, and he strives to discriminate between them. Such a sober alcoholic achieves a kind of serenity that permits him to face his fears and desires, and although he is still far from perfect in his understanding, he persists from day to day in his sobriety. Some alcoholics who are not so fortunate may stay “dry” for long periods but remain chronically unhappy, burdened with fears, and oppressed with unsatisfied desires.

***Are there substitute activities that the alcoholic might adopt?***

Alcoholics who are “dry” but unhappy and who have not yet achieved a productive sober life may become victims of other compulsions, such as compulsive eating, gambling, and overwork. Some become chronically ill, for example, with peptic ulcers, hypertension,

or cardiac disturbances. Some have psychotic breaks. The sober alcoholic who receives effective help usually engages in many forms of healthy substitute activity that replace the drinking pattern. He loses himself in his work, community service, Alcoholics Anonymous, hobbies, and wholesome homelife.

*When the alcoholic no longer seems to try to keep his excessive drinking a secret, is he deliberately choosing to show it to those around him?*

He may be. Most likely, however, he has reached the point where concealment is not possible any longer. In the interests of his own protection, the alcoholic usually tries to hide his drinking from family, employer, and friends; but prolonged sprees, loss of time from work, loss of jobs, and family disruption eventually make this impossible.

*Can displaying himself as helplessly drunk in the company of family and friends ever be a sign that the alcoholic wishes help?*

The alcoholic may be trying to say he needs aid. However, to make this an effective appeal, the alcoholic must be helped to recognize that he does indeed need therapy.

*In the extremes of alcoholic hallucination (as in delirium tremens), the alcoholic has terrifying visions, often of repulsive small animals. What causes delirium tremens (the d.t.'s)?*

Delirium tremens usually occurs within three or four days after an alcoholic stops drinking following a heavy drinking period, but may appear while the patient is still drinking. As the alcohol leaves the body (all the alcohol is cleared within about 24 hours) the nerve cells of the brain emerge from the anesthetizing effects and then go through a phase of overactivity that is especially marked in some alcoholics. Delirium tremens can be partly explained as caused by this overactivity in the brain areas responsible for hearing and vision. Instead of simply being *sensitive* to light and noise stimuli as in an ordinary hangover, the brain interprets sounds and visible stimuli (lights and shadows) as terrifying hallucinations.

*What can account for the fact that the hallucinations of alcoholics seem to be rather similar?*

The hallucinations of alcoholics are mainly visual and auditory, i.e., they involve seeing and hearing. Sometimes they concern the senses

of touch, taste, and smell. For the most part, the experience of hallucinating is awe-inspiring and fearful and the hallucinations themselves unpleasant; but pleasant hallucinatory experiences are also reported. The content of the experience varies. Human beings, animals, and things may be seen or heard; they may be large or very small. Sometimes color is impressive. The people or objects are frequently threatening and condemnatory. The hallucinatory material may be a complex result triggered off by visual or auditory stimuli—moving shadows, lights, or sounds in the person's room. It may also arise entirely within the individual's disordered brain. Some alcoholics continue to hallucinate for many weeks or months, and in such cases a differential diagnosis, perhaps of schizophrenia, is to be considered.

To the extent that hallucinations of alcoholics are all rather similar (although varying within the limits indicated), the explanation must lie in the fact that heavy alcoholization and withdrawal affect the nervous and brain organization in a characteristic way. The differences in the individuals' symptoms may be ascribed to cultural, educational, and psychological differences.

***Is the alcoholic in danger of committing suicide during these hallucinations?***

Yes. He may be told to destroy himself, and may feel so condemned that suicide seems the only course.

***Is the alcoholic a danger to others during the state of d.t.'s?***

Yes. The content of his hallucinations may lead him to attack those around him.

***Can an alcoholic be cured of drinking without his knowledge and cooperation?***

No. The rehabilitation of an alcoholic depends upon his own motivation and efforts, preferably in cooperation with his family, all working in coordination with a competent therapist.

***Is there any drug that can be added to his food or drink secretly that will make him turn against alcohol?***

No. This is a dangerous and foolhardy practice that should be condemned. Such a method can only fail.



***Is there any drug that the alcoholic can agree to take that will make him allergic to alcohol?***

Yes. The drug, disulfiram (Antabuse), can be taken by the alcoholic. This drug by itself, taken daily in proper dosage, does not have any noticeable effect. However, it renders the person sensitive to alcohol with the result that if he drinks, he gets—within a few minutes—a violent reaction in which his skin blood vessels dilate, his blood pressure falls, and he experiences headache, dizziness, faintness, nausea, pounding heart palpitations, and other acute, dramatic, and frightening symptoms. This Antabuse-alcohol reaction lasts about one hour and leaves the individual limp and exhausted.

The best way for most alcoholics to use Antabuse is as a means of self-enforcement of their own motivation for day-to-day abstinence. Ideally, the patient should monitor his own daily administration of Antabuse; that is, he should not delegate the responsibility for his taking the drug (and hence for his own sobriety) to any other person. Rightly used, Antabuse is not a kind of “policeman” but becomes an adjunct by which the patient ensures his sobriety a day at a time while he works on his problems. The patient takes his Antabuse each day after having reexperienced the conviction that he is indeed powerless over alcohol and that his life with alcohol has become unmanageable. He then decides that he wishes to try another day of sobriety. If he can accept this, he takes the Antabuse and does not have to worry about the matter again until the next day. Another chemical substance, calcium carbamide (Temposil), acts much like Antabuse and can be used in the same way.

***What is the rate of success of treatment with Antabuse?***

Antabuse is an adjunct to therapy. The rate of success with its use depends upon the individuals, the treatment setting, and the total treatment plan. In our controlled study of Antabuse, in which individuals began treatment in the hospital and continued for a year or more in an outpatient clinic, it was found that 76.5 per cent of 1,020 persons using Antabuse showed benefit as contrasted with 55 per cent of persons who showed improvement in a group of 484 controls. These differences are statistically significant. The follow-up record of the Antabuse group is also better than in the control group. Persons in the forty to forty-four-year age group were the most successful in treatment in both the Antabuse and control groups. An important factor in

the greater success of the Antabuse group seems to be that this treatment method attracts the more highly motivated alcoholics.

***Will the alcoholic stop drinking if he can become convinced when sober that his drinking is harming himself and those around him?***

He may. He will surely not work seriously at his problems unless he is convinced that he is harming his own life and the lives of those around him by his drinking. The best and most effective motive for sobriety is the conviction that one's own life, health, and welfare absolutely depend upon it. The therapist can help his patient strengthen this motivation.

***Is an alcoholic ever sincere when he promises his loved ones, or his employer, that he will stop drinking?***

Yes, very often. It is characteristic of an alcoholic to feel that his most recent bout with alcohol will be his last one. He is particularly likely to feel this way just after recovery from a drinking spree. Sometimes he makes such promises to get his family and employer "off his back," but quite often he really believes he can stop by himself. He seems to want to underestimate the problem. Frequently he will say, "If I keep away from that first drink, I know everything will be all right." And, at first, he usually does not face the fact that abstinence will bring new problems unrelated to drinking. The role of the therapist is partly to help the patient to adjust to the problems of an alcohol-free life.

***Does it often happen that alcoholics can, alone and by using their willpower, stop drinking to excess?***

If asked how they propose to stop drinking, many alcoholics will assert that they intend to exert their willpower to avoid alcohol and that they need no outside help. This approach is rarely successful for more than a limited period. Some alcoholics, however, after making their decision to stop drinking, do stop permanently, apparently without any therapy. In such cases, probably, there are unrecognized therapeutic factors acting in these individuals' lives.

***What is the record of success of the special "rest homes," where an alcoholic stays long enough to be "dried out"?***

There are no reliable figures for the overall success of special rest homes devoted simply to drying out the alcoholic. Probably the suc-

cess rate is fairly low because persons who are sent to such homes tend to be motivated toward handling the immediate acute drinking episode only. It is now recognized that treating an alcoholic only for his drinking episodes is inadequate. A planned, continuing program of rehabilitation is essential.

***What is Alcoholics Anonymous or A.A.?***

Alcoholics Anonymous is a fellowship of people banded together for the purpose of maintaining their sobriety. Founded in Akron, Ohio, in 1935, A.A. now has approximately 300,000 members in groups throughout the United States and the world. There are no dues or any membership requirements other than a sincere desire to stop drinking. Information about this organization can be obtained by looking under A.A. in the telephone book. A.A. functions with a minimum of organization. It is not officially connected with any groups—religious, medical, or other. It does not sponsor causes, discuss any issues, or get involved in controversies. It cooperates with doctors, nurses, clergymen, or any others who try to help alcoholics. A central feature of A.A. is the anonymity of its members, none of whom pretend to speak for the organization. There is a central office, the General Service Board of Alcoholics Anonymous, 305 East 45th Street, New York 17, N.Y., from which additional facts may be obtained.

***What is A.A.'s record of success in the curing of alcoholics?***

One of the strengths of A.A. is that it keeps no records of success; therefore, formal figures do not exist. Nevertheless, it is apparent that thousands of alcoholics have found and maintained their sobriety through the A.A. program. A large number of A.A.'s members are living alcohol-free lives.

***What are the methods by which A.A. has been able to terminate destructive drinking?***

The remarkable success of A.A. can be accounted for in large measure by the friendly, noncondemning, helpful fellowship it offers. Any alcoholic who wants help will find an A.A. member ready to call on him and give him aid. In the A.A. group meetings, the new member finds others who have been through experiences similar to his own, and who share with him the steps that have led them to sobriety. He selects a sponsor, who becomes his special friend and counselor. In

A.A. he learns that the members find support for their own sobriety in helping other alcoholics, and in living their lives in the present (a day or even an hour at a time), not bemoaning the past or cringing before the future. They pray for serenity to accept those things they cannot change, courage to change those things they can, and wisdom to distinguish between them.

At the heart of the A.A. program is a series of suggested steps. These steps begin with alcoholics' admission that they are powerless over alcohol and that their lives have become unmanageable. They recognize that a Power greater than themselves could restore them to sanity, and they turn their will and lives over to the care of God as they understand Him. Then follows a searching moral self-inventory, admission to God and another human being of the exact nature of their wrongs, the making of amends wherever possible, continuing personal inventory, and prompt admission whenever wrong. The core of these steps is spiritual. Through prayer and meditation the A.A. members seek to improve their conscious contact with God as they understand Him, and they ask for knowledge of God's will for them and for power to carry out that will. Having experienced a spiritual awakening through these steps, they try to convey this message to alcoholics and to practice these principles in all their affairs.

***Can marriage counseling help an alcoholic who is having marriage difficulties because of his drinking?***

Yes. In a family where one spouse is an alcoholic, there often are complex problems arising from the alcoholism itself, in addition to problems that predate it. A helpful marriage counselor will be alert to the needs of such a family and will use judgment in referring members for treatment. In many families the nonalcoholic member needs therapy just as much as or even more than the alcoholic himself.

***What are the problems that might arise within the family of the alcoholic? How can the family learn to deal with them?***

Problems arise associated with the alcoholic's failure as a breadwinner, for example. There may be financial distress and actual want. The family suffers from neglect and emotional deprivation as well as from the alcoholic's notorious unpredictability. On one occasion he may punish the children for a type of behavior, and on another occasion, leave them alone or even reward them for similar behavior. There may also be such problems as physical violence and desertion.

Families of alcoholics tend to react first by denial of the problems and by efforts to live normally. However, as the alcoholic's condition progresses, there is more and more confusion since usually the family does not understand the basic causes of the difficulties. Without treatment the family may be hostile toward the alcoholic. Usually, as the alcoholic becomes less able to occupy a place of leadership and cooperation in the family, the family tends to take over responsibilities that he normally should assume. The alcoholic in such a family may be treated like a child or disregarded as ineffectual and burdensome. With therapy, however, the family can recognize the alcoholic's sickness and be spared the need of venting hostility upon him. So long as the alcoholic continues to drink, and behaves irresponsibly, the family must do its best to carry on in spite of him or without him or his leadership. This can, however, be learned and, indeed, must be achieved if the family is to maintain its integrity.

A problem arises associated with the alcoholic's attempt to return to normal family relationships as he becomes sober and abstinent. At first the family may be skeptical and may exhibit a wait and see attitude before taking him back to full status. Since the alcoholic may have many slips, the family will have to allow for the fact that he may indeed take over responsibilities only to let go of them repeatedly. This requires great understanding on the part of the family. Sometimes other members of the family develop psychological and other problems associated with the unwanted or unusual roles forced on them by the alcoholic's illness. Also, it is probably true that some psychologically disturbed or inadequate persons tend to marry alcoholics or those with a predisposition toward alcoholism.

*Have any groups been organized to deal with the problems of the family?*

Yes. The Al-Anon Family Groups are a fellowship of husbands, wives, relatives, and friends of problem drinkers who may or may not be members of Alcoholics Anonymous. The members of Al-Anon are banded together in the effort to solve their common problems in trying to understand the alcoholic and to deal with their own fears, insecurities, and warped personal lives resulting from alcoholism. Al-Anon is not a part of Alcoholics Anonymous; it is a separate fellowship. Both A.A. and Al-Anon are, however, closely related, and they cooperate with each other in every way possible. Al-Anon is like A.A. in

that it stresses the anonymity of its members. Information about the Al-Anon Family Group can be obtained by writing to Al-Anon Family Group Headquarters, Box 182, Madison Square Station, New York 10, New York.

The Alateen groups are made up of children of problem drinkers who find that meeting with children of other alcoholics is helpful. Even though the alcoholic parent may have joined A.A. and the non-alcoholic adult members of the family may have joined Al-Anon, the children can also play an important part in reuniting the family. Many Alateen groups have been formed for teen-agers and information about such groups may be obtained from the Al-Anon Family Group Headquarters.

***How can the family help to promote the cure of the alcoholic?***

The fact is that the alcoholic will become abstinent only when he deeply desires to do so. The family members can help by changing their attitudes toward the alcoholic's problems and by reducing their own anxieties and frustrations. A family's growing understanding of the alcoholic's problem may lead him to seek information or help far sooner than he might otherwise do. An understanding attitude may make the alcoholic realize that he has a drinking problem and motivate him to do something about it. The family can learn that pleading or censure or trying to make him stop drinking is quite ineffective. The alcoholic's drinking is compulsive and out of control and there is no moderation for him. His only hope is through total abstinence and the family, by understanding this, can often be very helpful.

Whether or not the nonalcoholic members of the family should drink is a matter of individual decision. Sometimes it is more helpful if the nonalcoholic members continue with their regular practice, be it abstinence or moderate drinking. Members of the family can help by talking such matters over in a quiet, understanding way with the alcoholic himself and so come to a mutually satisfactory decision. The family can help also by handling its own resentments of past events and its own anxieties for what may happen in the future and by avoiding senseless anger over the distressful things that the alcoholic does and says, remembering that he has a sickness. In this way the family can maintain its own strength and solidarity and provide environment that is more conducive to the alcoholic's recovery.

***Can psychiatry and psychoanalysis help to cure the alcoholic?***

Yes. The uncontrolled drinking of an alcoholic is symptomatic of underlying disturbances—probably psychological, social, cultural, spiritual, and metabolic in nature. Also, most alcoholics develop serious medical and psychological complications as a part of their illness. Psychiatry has resources that can be of powerful help in the recovery of the alcoholic. It is important that these resources be made available to the alcoholic in such form that he can appreciate and use. The particular approach to psychiatric treatment must depend upon the diagnosis of the individual. In actual practice, formal psychoanalytic treatment for an alcoholic is not often used, probably because most alcoholics cannot tolerate it. Where analysis has been indicated as the proper treatment, however, it has been shown to be successful.

***What is the nature of such treatment?***

One of the important research problems in this field is to try to determine what types of alcoholics do best with particular kinds of therapy. This has not yet been clearly worked out; therefore, much therapy for alcoholics is based on what produces best results for each individual. At the start, the therapist should be accepting of the alcoholic, noncondemnatory, and friendly. It is well that the therapist transmit to the patient his conviction that the patient's life is valuable and worth working for—that he is not an expendable reject.

Treatment must include management of immediate problems of alcohol intoxication and withdrawal by appropriate medical means. The acute personal, family, and job problems must be faced. Here the cooperative efforts of a therapeutic team are usually an advantage—the psychiatrist, internist, general practitioner, social worker, nurse, and clergyman working together. Psychiatric treatment may provide support, enlightenment, stimulus to insight and growth, and help toward a more mature handling of life's problems.

***When does the alcoholic become ready to seek effective help?***

An alcoholic becomes ready to seek help when he begins to face, realistically, how unhappy and disturbed his life has become and that he is powerless without outside help. In A.A. this is called the experience of "hitting bottom." This realization of need for help may come after loss of a job, disruption of the home, an automobile accident, or a succession of disasters, when the individual begins to face the fact

that he cannot go on—that he must surrender his immature, self-centered behavior and build a new way of life.

*When the alcoholic is being freed of his need to drink to excess, does he ever discover resistance to his sobriety from those around him?*

Yes. His drinking friends may seek to draw him back to drinking.

*Why is it that some of an alcoholic's closest relationships, based on his being an alcoholic, may not survive when he stops drinking?*

The sober alcoholic finds that old relationships based only on drinking now break up or acquire new meaning. Sometimes, a drinking alcoholic has relationships that depend upon his immaturity and inferiority. Such relationships do not survive as he advances and grows as a sober person.

*Does the marriage partner or parent who seemed most to suffer from the alcoholic's drinking, sometimes find the sober person less acceptable?*

Yes. Sometimes a parent derives an unconscious satisfaction in seeing a son or daughter kept servile, compliant, and passive as an alcoholic. Such an alcoholic in attaining sobriety may now become a quite different kind of person and even become unacceptable to the parent. Similarly a spouse of a sober alcoholic sometimes finds that his or her mate is no longer dependent and childish and hence no longer fulfills the spouse's needs. Such cases point up the importance of therapy and counseling for both the alcoholic and the spouse (or parent) and for an understanding that the problems are not completely solved by sobriety alone. Indeed, with sobriety, a whole new set of problems come to the alcoholic and his family.

*Is it true that the cured alcoholic cannot usually become a casual or moderate drinker?*

Yes. In fact, for all practical purposes, it is correct to say that the recovering alcoholic can never again expect to drink safely. Just why this is so is not known. Is there some irreversible, continuing metabolic defect? Or are there psychological scars that cannot be eradicated? At present, the most realistic goals of therapy for an alcoholic must include the aim of helping him become the kind of person who can live without alcohol altogether.



***Are there ever any spontaneous cures in which it would appear that (after many years of life-destructive drinking) the alcoholic rehabilitates himself, or allows himself to be saved?***

Yes. Studies show that up to 10 per cent of alcoholics may apparently spontaneously stop drinking after several years of active alcoholism. The factors responsible for these "cures" are not understood.

***What can the community do to prevent or reduce alcoholism? The individual?***

Probably the most effective action the community can take to prevent or reduce alcoholism is to promote, by educational and other means, wholesome attitudes toward alcohol problems and sound knowledge about alcoholism. Studies show that in cultures with strong sanctions against drunkenness there are lower rates of alcoholism than in societies where drunkenness is acceptable behavior.

An individual can reduce the likelihood of alcoholism in himself by being informed about the dangers and early signs of alcohol misuse and by practicing principles of sound spiritual, mental, and physical health in his life. Those who find themselves using alcohol to handle fears, anxiety, tension, and chronic unhappiness should seek professional counseling from a clergyman, physician, or psychiatrist.

***Can legislation help prevent excessive drinking?***

Yes, to a great extent it can. Legislation regulating the sale of alcoholic beverages and establishing taxes on such beverages can considerably influence the total sales and consumption of alcohol. The details of alcoholic beverage control laws are the subject of discussion and disagreement. There is divided opinion as to whether or not alcohol should be sold in package stores, by the drink, or in smaller-sized containers. It is claimed that if the control laws are too lax, excessive drinking, with attendant problems, increases. On the other hand, if taxes rise and control becomes more strict, a point may be reached at which illegal liquor production and sale, with resultant evils, become serious.

***What was responsible for the failure of the Prohibition Enforcement Act, which was ratified as the Eighteenth Amendment to the Constitution in 1919, and repealed in 1933?***

Opinions vary greatly as to the reasons for the failure of national prohibition. It is quite obvious that the public support necessary to

make enforcement effective was lacking. Many people who favored some governmental control measures became deeply concerned when bootlegging and crime flourished under prohibition. It seems unlikely that a national prohibition law would be passed or enforced today, and most informed commentators on this matter state that national prohibition is not a desirable method of dealing with alcohol problems.

*How can education help to reduce alcoholism?*

The goals of education about alcohol and alcoholism are the subject of controversy. Public education should be factual, objective, and scientifically accurate and should encourage careful thought and decision-making. It should be emphasized that decisions about alcohol are important and should be based upon sound information.

*What can parents do to help their children develop healthy attitudes about alcohol?*

Parents can do much by providing a loving, well-disciplined home in which education about alcohol is consistent with established practices of the parents. Children should be taught the reasons for the particular customs of alcohol use or nonuse in their own homes and how other practices differ from those of their family. A stable home that permits children to grow in ability to face responsibilities and confront problems within a setting of loving interrelationships is the best guarantee that children will be emotionally healthy and, therefore, least likely to become alcoholics.

# ANIMAL PSYCHOLOGY

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## ***What is animal psychology?***

Animal psychology, or, as it is more usually called, comparative psychology, is the study of the behavior of animals and of the ability of animals, by their behavior, to adjust to the conditions of their environment.

## ***What are its main aims?***

They are to gain understanding of the behavior of animals, considered as a part of nature in which the investigators are interested; to investigate the relationship between the nervous system and behavior; to study how other aspects of physiological functioning, such as the workings of the endocrine system, affect the behavior of the animals; to develop understanding of the way differences in the behavior of different kinds of animals are related to differences in their structure and physiology; to study the laws of learning and of complex adjustments to the environment; and, in general, to gain understanding of the mechanisms and organization of behavior and of psychological processes by studying the ways in which different kinds of animals differ, and the ways in which they are similar, in their behavior.

## ***What are the different approaches or methods used in animal psychology?***

Different methods are used for the study of different kinds of problems, of different kinds of animals, and at different stages in the development of the same kind of animal. For example, careful observation of the behavior of an animal in its natural setting is often the first stage in the formulation and investigation of complex problems concerning the organization and causation of its behavior. Observation of how the same animal may behave differently under different circumstances gives clues to the understanding of what makes the animal act the way it does. For more refined and confident statements about the

causes of the animal's behavior, however, recourse is usually had to the method of *experiment*, in which the investigator himself controls such relevant conditions as the age of the animal, the kind of experience it has had, the kind of parents it has come from, the kind of environment in which it is tested, the kind of problems it must solve, etc.

Some special methods might be used, and are sufficiently characteristic of various schools of animal psychology to warrant special mention here. The *maze*, in which the animal must learn to find its way through a series of alleys in which it has a number of opportunities to choose between a correct and an incorrect path, is often used in the study of animal learning. *Problem boxes*, in which the animal must manipulate various levers in order to get out of the box, or in order to achieve some reward, are also used for the study of more complex forms of learning. *Conditioning* is a procedure in which an animal gradually becomes able to make some response to a stimulus that was originally ineffective, because this stimulus is repeatedly presented by the experimenter in association with a stimulus to which the animal already responds. This procedure is the basis for many studies of the limits of an animal's sensitivity to various stimuli, and is also used when studying some types of learning processes. The *Skinner box* is a device in which an animal performs some act, such as the pressing of a lever, and is rewarded for doing so by the experimenter. Systematic variation of the conditions under which the animal will receive a reward, and of the amount and kind of lever-pressing which he must do in order to receive it, have been the basis for many studies of animal motivation, learning, and perception.

These methods are selected for mention, not because they are the only, or necessarily the best, methods in use, but because they are most typical of the kind of activity found in laboratories of animal psychology in 1962.

*Is the study of animal psychology in the United States different from that in other countries?*

Comparative psychology in the United States developed primarily in the context of the intense interest of American psychologists during the early part of the century in the study of learning and individual differences. It was, therefore, for a long time dominated by studies of the "intelligence" and learning ability of animals, and the maze was the primary instrument associated with the study of animal psychology. Even in 1962, studies of problems related to learning and to problems

of "general" psychology, such as the nature of sensory abilities, the origin of individual differences in ability, etc., tend to dominate studies of animal behavior in the United States.

In Europe, starting in the 1930's, a significant interest in the study of animal behavior developed, not primarily among psychologists, but among zoologists. As might be expected in the case of zoologists, their interest centered on the problems of the evolution of behavior, and of the nature of behavioral adaptation to the animal's natural environment. As of 1962, European zoologists are much more interested in problems of animal learning than formerly, and American comparative psychologists are much more interested in problems of naturally occurring patterns of animal behavior than formerly, but it is still correct to say that there is some difference in orientation between these groups of workers in their respective countries.

***Where is research in animal psychology primarily done?***

University departments of psychology and of zoology are the principal locations of research in animal psychology. In addition, there are laboratories located outside of universities for the study of various aspects of animal psychology, particularly those with practical applications. For example, many pharmaceutical manufacturers maintain laboratories for animal psychology for the study of the effects of drugs upon behavior. Various government agencies concerned with the organization of space exploration maintain laboratories in which animals are trained and used for the study of the physiological and behavioral effects of conditions in outer space.

***What is the professional background of people involved in animal psychology?***

Animal psychologists are almost invariably professional psychologists whose training has been concentrated on experimental psychology. At present, professional status in any field of psychology, including animal psychology, requires possession of a Ph.D. degree. In addition, many zoologists, both in the United States and in Europe, study the problems of animal behavior.

***What is the attitude of the community and of the medical profession toward animal psychology?***

Most research in animal psychology is not of direct interest or relevance to medical research or practice. There are, however, a

number of types of research on animal behavior in which the medical profession displays a keen interest. These include studies of behavioral development, studies of effects of hormones on behavior, studies of the effects of various types of damage to the nervous system upon different behavioral capacities, studies of conflict and "neurosis" with animals, etc.

Research in animal psychology is supported on a substantial scale by various government agencies, including those concerned with the support of basic or fundamental research, and those concerned with the support of research in the medical sciences.

*What is the attitude of the psychological profession toward animal psychology?*

Animal psychology is a field of experimental psychology. Experiments with animals have played a role in the formulation and development of most of the important systematic theories of psychology. Psychologists generally regard animal psychology with the same attitude they have toward the general field of experimental psychology. Clinical psychologists, who are, of course, concerned primarily with the psychological problems of human beings, and academic psychologists, who are concerned primarily with research and university teaching in psychology, tend, in general, to have somewhat different attitudes toward experimental psychology. Many clinicians are inclined to regard the concerns of experimental psychology as being somewhat remote from what they feel are the major problems of psychology, while some academic psychologists tend to regard the practices of clinical psychology as being, so far, inadequately grounded in scientific knowledge. There are, however, notable trends toward closer integration of the work of clinical and experimental psychologists.

*What might be the basis for a positive or negative attitude toward animal psychology?*

Human beings are, in many ways, qualitatively different from even the highest and most advanced of the lower animals. The possession of language enables the experience of one generation of human beings to be transmitted to subsequent generations through symbols, a mode of communication which is unavailable to any other animal. This fact has wide implications for the development of human intelligence and personality.

From these considerations, persons who feel that human beings are so different from animals that any study of animal behavior cannot be relevant to the understanding of anything important about human beings, may tend to feel that animal psychology is of little importance.

On the other hand, human beings are animals, and have evolved from lower animals, and this evolutionary continuity is the basis for the feeling that the study of animal behavior is very valuable in understanding various aspects of the behavior of human beings, provided that the differences among different kinds of animals are given appropriate consideration, along with the similarities among them. Persons with such an orientation are likely to feel that animal psychology is a valuable and important field of psychology.

*What aspects of animal psychology have been of particular interest to psychiatrists?*

Psychiatrists, and students of human behavior generally, have been much interested in studies of instinctive behavior in animals, studies of conflict and "neurotic" behavior, studies of the effects of early experience upon later behavioral development, studies of the effects of drugs upon behavior and upon the nervous system, studies of the effects of various types of brain damage upon behavior, etc. All these aspects of behavior have been actively investigated by students of animal behavior. Examples of some of these will be given below in sufficient detail to provide some idea of the relationships between animal studies and the various problems of general and clinical psychology.

*What have been the results of animal psychology in its application to the problems of psychological development?*

A number of students of animal behavior have called attention to the fact that, under normal conditions of development, many animals can learn particular kinds of things at particular ages. Most investigators speak of a "sensitive period," to describe the ages or stages of development at which animals are particularly sensitive to the effects of particular kinds of experience. For example, newly born or newly hatched young of many species of birds and mammals do not "know" what a member of their species looks like, but must learn this through their experience with their mother, or with the animal that is the source of their earliest feedings. In some cases, the animal's ability to

learn to follow or to associate with a member of its own species, rather than with other animals, is restricted to a short period during its early life. Such learning, restricted to a short period during early life, is called "imprinting," and the sensitive period is referred to as the "imprinting period."

Studies of the relationship between a mother and young monkeys have been of interest, since they have shown that young monkeys are attracted by certain sensory qualities of the mother, regardless of whether the mother, having those sensory qualities, gives milk or not.

Many studies have shown that the kind of environment in which rats, dogs, and other animals are reared during early life, has a great influence on their later learning abilities, perceptual characteristics, emotional organization, etc.

All these studies are of obvious interest to one who wishes to understand the way in which events occurring during the development of an animal (or of a person) help to shape psychological capacities and characteristics.

*How are the results of the study of animal psychology related to the study of drugs?*

One of the most striking developments in psychiatric practice during recent years has been that of the use of drugs in ameliorating the symptoms of various psychiatric disorders. In particular, the types of drugs called "tranquilizers" are proving useful in reducing anxiety, in controlling the agitation of severely disturbed patients, and sometimes thereby making it possible for such patients to come into more effective contact with the world around them. The tranquilizing effect of one of the most popular of these drugs was discovered when it was being routinely tested in the laboratories of a pharmaceutical company. In order to determine whether the drug was poisonous or dangerous, doses of it were given to several "wild-caught" monkeys, which are usually extremely dangerous animals and must be handled with great care. A striking effect was noted: the previously vicious and excitable monkeys became quiet, friendly, and tractable, without seeming in any way lethargic or "dopey." Similar effects were quickly noted in human patients. Many pharmaceutical manufacturing firms now routinely test new drugs for possible psychiatric use by first administering them to animal subjects, in order to determine the effects of these drugs upon various measures of emotionality, alertness, learning ability, etc.



***How are the results of the study of animal psychology related to the study of the nervous system?***

Most of our detailed knowledge of the functioning of the nervous system has been gained through experimentation with animal subjects. Scientists who study such matters use a number of techniques: (1) if a small part of the brain is damaged or removed, the resulting defects or deficiencies in the animal's ability to move, perceive, learn or orient, or to perform various "instinctive" activities give important clues to the way in which that part of the brain functions in the intact animal; (2) if small wires are implanted into specific places in the brain, it is possible to record the electrical activity that occurs in the brain during the performance of various kinds of behavior, and thus to find out which parts of the brain are involved, and in what way, in different kinds of behavior; (3) similar wires may be used to stimulate different parts of the brain by electric shock, and to observe what kinds of changes in behavior take place from thus setting into activity different parts of the brain.

By such methods, it has been possible to identify specific places in the brain that seem to be intimately involved in the organization of specific kinds of behavior. For example, there are areas in the brain, the stimulation of which cause excessive drinking, and damage to which interferes with drinking behavior. The so-called "pleasure centers" are areas that a rat, if given the opportunity, will strive to stimulate electrically; for example, the animal will keep pressing a bar indefinitely if he gets a shock in this part of the brain periodically, so long as he keeps pressing the bar. There are other areas that the animal will work very hard to *avoid* having stimulated.

Similarly, the stimulation of certain areas gives rise to apparent fear behavior, and damage to these areas inhibits or prevents the normal expression of fear and other emotions.

Obviously, studies of the effects of damage to and stimulation of the brains of experimental animals, particularly of higher animals like monkeys and chimpanzees, whose brains resemble human brains, are very helpful in understanding the ways in which accidental damage to the brains of human beings affects their behavior and psychological capacities.

# ANXIETY

by JUDD MARMOR, M.D.

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## ***What is meant by anxiety?***

Anxiety refers to a psychophysiological (mind-body) state that occurs when an individual experiences a sense of impending or threatening danger. Anxiety is a normal or natural response and is as important to the safety and security of the human organism as is the ability to perceive pain. The reaction of anxiety may be of varying degrees of intensity, ranging from a mild sense of inner tension to extreme states of terror or panic.

## ***How does anxiety differ from fear?***

Actually anxiety and fear are identical physiological reactions, but they differ psychologically. Fear is a reaction to a known, tangible, objective danger (e.g., Johnny is afraid of dogs), whereas anxiety usually refers to unknown, intangible, subjective dangers (e.g., Jack is anxious about the future). Sometimes the term "anxiety" is used to cover both kinds of reaction, but then a distinction is made between reactions to realistic danger—realistic anxiety—and reactions to unrealistic danger—neurotic anxiety.

## ***How is anxiety manifested psychologically?***

Anxiety is manifested in a variety of ways. Sometimes the individual experiences it merely as a sense of nameless dread, without being able to identify why, or of what, he is fearful. Psychiatrists call this "free-floating anxiety," to indicate that it is not attached to any specific object. When an individual's main symptom is that of free-floating anxiety, psychiatrists diagnose the condition as an *anxiety state*.

On the other hand, anxiety may be related to specific ideas or objects, such as a fear of death, cancer, high places, closed areas, etc. When the anxiety is attached to a specific object in this manner, psychiatrists generally refer to it as a *phobia* (from the Greek φόβος-fear). There are numerous hyphenated Greek names for such phobias, each referring

to an anxiety attached to a specific idea or object, e.g., agoraphobia (fear of open spaces), claustrophobia (fear of closed areas), acrophobia (fear of heights), etc. (See *Phobia*)

Whether anxiety is experienced as free-floating or in relationship to some specific idea or object, the subjective physiological reaction is the same.

*What are the physiological manifestations of anxiety?*

The physiological manifestations of anxiety can be divided into two main groupings: (1) those which the individual can perceive; (2) those which he cannot perceive. At a conscious level, the reactions most commonly perceived are shortness of breath and rapid beating of the heart. In addition, there may be skipped heart beats, which are experienced as heart palpitations. Also, there may be dryness of the mouth, a sense of tightness in the head (like a tight band around it), and a feeling of tightness in the throat (sometimes experienced as a "lump" in the throat). In extreme instances there may be vomiting, diarrhea, or fainting. Not infrequently there is a need to urinate more often. Most people lose their appetites when they are anxious, but there are some who react with a need to eat excessively. The latter reaction is a significant factor in many cases of obesity. Insomnia is a common accompaniment of anxiety, but one occasionally sees people who react to anxiety with exaggerated needs for sleep. Feelings of chronic fatigue can be a consequence of extended states of anxiety.

These more obvious bodily reactions are always accompanied by other complex responses that are not subjectively perceptible. These changes are brought about through the action of the "autonomic" nervous system (called autonomic because it is not subject to direct, conscious control). They are all of a nature which will enable the body to mobilize itself more effectively to deal with the threatened danger, either by fleeing from it, or by fighting against it (fight or flight). Every system of the body is involved to some degree in this emergency mobilization. Some of the more outstanding of these changes are the outpouring of adrenalin and other hormonal substances from the adrenal glands, which in turn cause the liver to release glucose into the bloodstream so that the muscles will then have the glucose available for quick energy. The heart is caused to beat faster and blood pressure is raised, thus pumping the blood, with its oxygen, glucose, and other nutrient supplies, more quickly to the muscles and to the central nervous system. At the same time, processes in the body that are not

immediately useful for fight or flight, such as digestion, or sexual desire, are likely to be slowed or inhibited.

***Do all individuals experience anxiety?***

Yes, at various times in their lives. Anxiety may be normal or it may be neurotic. It is not the capacity to experience anxiety, but what we get anxious about that determines whether or not the anxiety is normal.

***Are there differences between men and women in their capacity to experience anxiety? Among cultural groups?***

There are no innate differences between men and women, children or adults, or among different national groups in general, in the capacity to experience anxiety. Whether or not a person will react with anxiety depends on whether or not he or she feels threatened. This means that the capacity to experience anxiety depends on two principal factors: (1) on the nature of the threatening object or situation; (2) on the individual's sense of inner strength and his feeling that he has the ability to cope with the danger. Clearly, therefore, women or children may tend to feel more anxious in certain situations because they may feel relatively more helpless than an adult male. Regardless of age or sex, however, people who inwardly feel strong, loved, and self-confident will tend to have a higher threshold for anxiety than people who inwardly feel weak, unloved, and inadequate.

Cultural differences related to anxiety are more likely to be seen in outward manifestations than in actual inner feelings. For example, Anglo-Saxon people, who, in general, are trained to keep their feelings under control, are less likely to show their anxiety outwardly than are people of Latin origins, but this does not mean that Anglo-Saxons may not experience anxiety inwardly just as strongly as the Latins.

***Are there individual hereditary differences in anxiety reactions?***

Although scientists have not discovered conclusive proof on this point as yet, the weight of evidence is that there are individual hereditary differences in the capacity to react with anxiety, just as there are individual differences in the capacity to react with pain. Some people, from birth and throughout their lives, seem to have more apprehensive types of temperament, while others are more phlegmatic. It should be remembered, however, that these differences do not, by themselves, indi-

cate any greater or lesser tendency toward mental health. A greater tendency to react with anxiety can be compared to high sensitivity. Under some circumstances this is advantageous and leads to greater awareness and understanding of other people's feelings, and of currents and cross-currents in the world about us. On the other hand, under less favorable circumstances, anxiety can lead to overreactions and less effective coping with problems at hand. By the same token, a failure to react with anxiety can also be a disadvantage, if as a result the individual fails to be alerted to a possible source of danger in the world around him, and thus fails to prepare himself for it.

### *What is the source of neurotic anxiety?*

One explanation has come from Sigmund Freud, the founder of psychoanalysis, who formulated the hypothesis that fundamentally all anxiety arises either out of the fear of losing love or the fear of being physically hurt in some way. These two basic fears are sometimes classified by psychoanalysts under the symbolic concept of "castration anxiety." Thus when an individual has a need or impulse, the satisfaction or expression of which might cause him either to lose love (i.e., to face disapproval) or to be physically hurt (i.e., to face punishment), a conflict develops that reflects itself in feelings of anxiety. As a result of the conflict, the need or impulse (for example, a sexual or aggressive one) tends to become repressed (i.e., kept out of conscious awareness). The individual then experiences anxiety without knowing its origin. Another way of neurotically dealing with anxiety is to displace it from its original source onto some other object, which then becomes the basis for a phobia. Thus a conscious fear of open spaces (agoraphobia) might be a displacement from a repressed, unconscious fear of being exposed to sexual temptation, or a fear of insanity might be a displacement from an unconscious fear of one's angry impulses getting out of control.

In contrast to such neurotic forms of anxiety, a normal anxiety arises out of realistic situations which threaten one's basic sense of security. Examples of this would be the anxiety most people feel when faced with imminent economic hardships or actual illness.

### *Why is our current era called The Age of Anxiety?*

The increasing complexities of modern society, the Depression of the 1930's, the two world wars, and the "cold war" between East and West with its threat of a mutually annihilating nuclear holocaust are

some of the major factors that have created feelings of widespread and pervasive emotional insecurity and tension, and have resulted in our modern era being dubbed "The Age of Anxiety." Some social historians believe that the mid-twentieth century is more anxiety-ridden than any other era in history since the Middle Ages.

***How is anxiety treated?***

Anxiety can be treated either by dealing with the symptoms, or by an effort to deal with the factors causing it. Symptomatic treatment consists of the administration of sedative or tranquilizing drugs that reduce the individual's capacity to feel anxious. Such treatment is equivalent to prescribing aspirin for a headache; it reduces the pain without removing the cause of the pain. Nevertheless, such treatment is often extremely useful since excessive anxiety may be so incapacitating that it may prevent the individual from doing anything constructive about reaching the sources of his difficulties. Most physicians, however, disapprove of medication with sedatives or tranquilizers unless the patient is under medical supervision. There are a number of good reasons for this. All sedatives and tranquilizers are capable of causing occasional physical side reactions, which can become serious if not observed in time. There is also a danger of addiction occurring if some of these drugs are taken over too long a period of time or in too great quantities. If the drugs are taken merely to control the anxiety, and nothing is done to uncover and treat the underlying causes, the patient's actual problems may increase to a point where even the use of drugs can no longer protect him from serious emotional disturbances or the difficulties of life. Finally, the use of some of these drugs could interfere with the useful, beneficial response of normal anxiety.

For these reasons, psychiatrists generally advise that whether or not symptomatic relief is obtained from drugs, patients with neurotic anxiety symptoms should have treatment that is directed toward the underlying causes of the anxiety. Such psychotherapy tries to uncover the unconscious conflicts which the patient is repressing, and to enable the patient to deal with them in a more constructive manner.

# APTITUDE AND VOCATIONAL TESTING

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## ***What is aptitude and vocational testing?***

Aptitude and vocational testing involves the administering of tests—by a psychologist, vocational counselor, teacher, test specialist, or personnel expert—to an individual for the purpose of determining his suitability for employment or training. The individual may be given a single test or, more likely, a battery of tests designed to measure his abilities, capacities or aptitudes, skills, interests, or personality traits, any one or all of which may be predictive of his success on a job assignment or in a training course.

## ***Is aptitude testing the same as vocational testing? If not, how do they differ?***

Aptitude testing denotes less intensive testing, with a more narrow range of tests, than does vocational testing. It measures the capacity, or latent ability, of an individual to learn a job or master a training course. Examples of specific aptitudes are: mechanical, clerical, manual, linguistic, musical, and scholastic. Vocational testing generally includes, in addition to aptitude tests, tests of intelligence, proficiency, personality, and interests, thus giving an integrated picture of the individual's intellectual endowments and personality resources.

## ***Are tests of skill and performance (e.g., of typing and driving) considered to be aptitude and vocational tests?***

Tests of typing and driving are called "proficiency tests" for they relate to the degree of skill or ability demonstrated in performing a task. Sometimes the terms "proficiency test" and "achievement test" are used interchangeably for they denote what has already been learned and is now being demonstrated. Some investigators prefer to reserve "proficiency tests" and "trade tests" for the measurement of job skills while limiting "achievement tests" to performance in school subjects.

Though "proficiency" or "achievement" describes present skill or knowledge while "aptitude" refers to capacity for acquiring future abil-

ity, the difference between the two tests lies less in their content than in their use. For example, a score on a typing test may be indicative of aptitude for learning stenography, and results on an arithmetic achievement test may be an index of aptitude for mastering engineering skills. Before making such assumptions, however, one must subject proficiency or achievement tests to the same validating process applying to aptitude tests; that is, there must be a proven relationship between test scores and performance on the job or training course.

***What aptitudes are most effectively determined by testing?***

The clerical or mechanical aptitudes that are second only to general ability in the number of tests available are most effectively determined by testing. Since so large a part of the working population is engaged in clerical or production work, investigators have been particularly active, through the years, in attempting to identify factors contributing to satisfactory job performance in these two areas, which are at the same time measurable. Clerical aptitude is determined by tests of perceptual speed and accuracy. Intellectual factors, while not showing a significantly high correlation with clerical success, show a rising relationship with the degree of responsibility undertaken; hence tests of mental alertness have been included in clerical batteries as well as tests of proficiency in arithmetic and language. Tests of mechanical aptitude generally include measures of spatial relations, mechanical comprehension, manipulative skills, and an understanding of mechanical principles.

***What vocations have the best record of results through testing?***

In line with the development of aptitude testing, the highest "batting average" in vocational prediction is obtained with clerical jobs and jobs requiring mechanical and manual skills. While some progress is being made in the sales area and with the professions, less valid predictions are forthcoming with jobs in these fields for the reason that personality traits and interests play an important role in success and these cannot be identified and measured as easily as can aptitudes and skills.

***In what areas of activity is the use of aptitude and vocational testing winning the greatest acceptance?***

Testing plays a prominent role in vocational counseling programs in schools and colleges and in public and private agencies. Testing



programs continue to grow in business and industry where considerable weight may be assigned to tests in personnel selection. As representative of governmental interest, the United States Employment Service, after intensive research into occupations, has brought out a comprehensive General Aptitude Test Battery available through the state employment services and administered to job applicants for the purpose of directing them into suitable work.

***Can there be too much reliance on these tests in making personnel decisions in business and industry? What measures are taken to reduce possibilities of overemphasis?***

It is certainly true that some businesses still rely too heavily on test results, considering them a panacea for all problems relating to selection decisions. During the last few years, however, much has been written in professional journals about the limitations of tests, and conference lectures and discussions have dealt with the subject quite frankly. It has been emphasized that because of their margin of error, tests only supplement, never replace, other methods of appraising individuals. Even if abilities, aptitudes, proficiencies, personality traits, and interests could be measured with the highest degree of accuracy, one still would not be able to predict exactly how a man might actually perform on a given job, but only how he is expected to perform. Many personnel workers and businessmen have been heeding the advice of experts and consequently have been placing less weight on test findings in the selection procedure than on interview impressions, past achievements, interests, and training.

***Do individuals applying for a job sometimes show resistance to aptitude and vocational testing? What effect does this have on testing and hiring policy?***

Even when applicants are aware that tests are required in the hiring procedure they may resent taking them, feeling that they are unfair and discriminating, and that they really do not measure practical performance since problems presented on paper bear little resemblance to actual tasks on the job. Because applicants are likely to be critical and fearful lest they do poorly, personnel departments have concerned themselves with the proper introduction and administration of tests, thereby minimizing hostile feelings and tensions and encouraging applicants to do their best. Unless the importance of testing is played down, and it is presented as just one of several selection tools, many

qualified applicants may decide not to apply for job openings. A well-planned selection program, however, may actually attract the better applicants.

***Can test results be deliberately faked by the individual being tested? Can they be unconsciously faked or distorted?***

Despite an attempt by those devising tests to check on the honesty factor, some paper-and-pencil tests measuring personality traits and interests are particularly subject to faking. There is a greater incidence of this when tests are used for selection rather than for guidance. Test items are quite obvious to a reasonably intelligent person so that if he is highly motivated to secure a particular position, he may well put himself in the most favorable light by indicating that he possesses certain desirable interests and personality characteristics. Though an individual may wish to be honest, he may not always know how to interpret the questions asked of him, or he may actually lack the insight needed to describe his behavior accurately. Projective tests, less subject to the influences of faking, have been substituted for the questionnaire personality test in instances where trained psychologists are available to interpret the material. (See *Psychodiagnostic and Personality Testing*)

***What is the record of success of aptitude and vocational testing in helping individuals find work most suitable to them?***

Though tests do not provide us with all information necessary to make accurate job predictions, but merely supplement material derived from other sources, a valid battery of tests, competently administered and skillfully interpreted, can throw light on an individual's assets and liabilities, enabling him to make a wiser occupational choice than if he had not had the benefit of such an evaluation. Tests help him to decide whether he has the aptitude to complete training in specific courses and may suggest capabilities in new areas of work of which he was totally unaware. It has been generally conceded that testing does a more effective job of predicting vocational success than any other selection tool.

***How soon can aptitudes be recognized? Do they remain stable?***

In his book, *Aptitudes and Aptitude Testing*, Walter V. Bingham points out that aptitudes become crystallized in early childhood and remain relatively stable from then on. He says, however, "Favorable

opportunities encourage the ripening of latent talents while other aptitudes may lapse through lack of timely exercise."

***How early in life can aptitude and vocational tests be useful tools?***

An appropriate time to introduce vocational tests is during the junior high school period just prior to entering senior high school when a student must select a course of study. Tests will indicate to teachers and parents whether it would be best for him to enroll in a shop course, a commercial course, or an academic course.

***What cognizance must be taken of the intellectual factor in vocational counseling and selection?***

Psychologists and vocational counselors agree that the mental ability levels of individuals in the various occupational groups differ, and that the probability of success in a given occupation is likely to be greater if an individual falls within the preferred range. However, there is considerable overlapping between occupations so that it is possible for an individual with a low level of mental ability to function well, if he compensates for intelligence by excelling in other factors known to have a positive relationship to job success.

***What is the significance of personality and interest measures in a battery of vocational tests?***

Personality traits and interests are important factors in determining job success but it has not been easy to establish a clear-cut relationship between them. Since diverse personalities may be equally successful on the same job, it is difficult to know what constitutes the ideal personality of the engineer, the salesman, the doctor, the lawyer, and so on, through the list of occupations. Then, too, personalities vary with situations so that it is not unusual to find a person aggressive in one situation and withdrawn in another.

When an individual reveals interests similar to those of other persons in the occupation he expects to enter, he will most likely not only enjoy the work but also feel at home in his surroundings, deriving satisfaction from shared activities with colleagues. Though a relationship between interests and abilities has not yet been unequivocally established, it is possible that an individual is motivated to learn those things which interest him and, conversely, to acquire an interest in those things which he can do well.

***To what extent are aptitude and vocational tests administered in the schools?***

While educational achievement tests are rather routinely given to students from the elementary grades through high school, the extent of vocational testing varies with schools and localities. Much depends on community interest and on the importance attached to vocational guidance activities in specific school systems. The success of a vocational testing program is, in no small measure, dependent on the number of counselors available, their competence, and the time at their disposal for conferring with students on vocational problems.

***Can there be too much reliance on test results by schools? What measures are taken to reduce possibilities of overemphasis?***

There is always the danger that some teachers lacking adequate training in the proper use of tests may overemphasize their importance. Not infrequently students scoring low on tests are ignored while those scoring high are encouraged. Intelligent educational and vocational guidance programs in the schools are attempting to focus attention on the student's total personality—his intellectual endowments as well as his personality resources—and are, therefore, supplementing test results with information derived from interviews, teachers' ratings, questionnaires, biographies, personnel records, etc.

***When might aptitude and vocational testing be recommended for an individual and by whom?***

An individual may be given vocational tests at various times in his life:

When he is ready for senior high school and must choose a course of study. Teachers or counselors may recommend that he take tests at this time.

Upon entering military service to determine his aptitudes for particular fields of specialization.

On availing himself of counseling at the Veterans Administration after leaving military service. Military authorities or other interested persons may suggest that he take advantage of such guidance.

Prior to entering college to determine his suitability for his intended major field of study or prior to his junior year in college when he must choose his major and minor courses. Recommendations may come from teachers or parents, or the student, himself, may feel a need for guidance.

Upon completing his education and applying for a job in business or industry where testing is a standard procedure.

When seeking vocational counseling recommended by his employer because of his inability to make a satisfactory job adjustment.

When being considered for a training program, job change, or promotion in business or industry on the recommendation of his supervisor or the personnel director.

***Where can one go or write for information in order to take vocational tests?***

One can consult the *Directory of American Psychological Services 1960* published by the American Board for Psychological Services at Glendale, Ohio, which is available at most libraries and which lists approved agencies or organizations offering vocational testing and counseling by city and state. Also available at libraries is the *Directory of Vocational Counseling Services* put out by the American Board on Professional Standards in Vocational Counseling, Inc., 1605 New Hampshire Avenue, N.W., Washington, D.C., which is under the American Personnel and Guidance Association. This, too, directs the individual to organizations offering educational and vocational guidance.

***What are the fees for vocational tests?***

Fees for vocational testing range anywhere from \$20 to \$250 with the average being approximately \$75. Much depends on how intensive a battery of tests is administered, some batteries taking as long as two full days. Tests such as the projective techniques, which require hours for interpretation by a highly trained psychologist, would be more costly, while a battery of objective tests, administered and scored in much less time, would be less expensive. (See *Psychodiagnostic and Personality Testing*)

***Are there any facilities for free or low-cost testing by government agencies or other organizations?***

Yes, at such federal and state agencies as the Veterans Administration or the state employment services (in connection with placement services) as well as at community agencies sponsored by local governments. There are, in addition, a few agencies supported by religious organizations offering free or low-cost testing and guidance services. Vocational and educational testing is generally free to students at colleges and universities where guidance and advisory centers are established.

***How is the validity of aptitude and vocational test methods and interpretations measured? How often are these measures applied?***

Establishing the validity of a test is a necessary step in determining whether it actually measures what it purports to measure. If a test or test battery is designed to predict job success or satisfactory completion of a professional course, it must differentiate between good and poor workers or between successful and unsuccessful students. Perhaps the most difficult task in establishing such validity is in identifying criteria of vocational success. Let us suppose, for example, that a psychologist wishes to validate a test to be used for the selection of salesmen. He must first ascertain what constitutes a measure of success. This is a complex problem, for salesmen perform a variety of duties in diverse occupational settings. Is the successful salesman one who gets the largest number of orders or orders of the greatest monetary value? Is he one who makes the most customer calls, opens the most new accounts, or gets the fewest customer complaints?

When a job analysis has been conducted and criteria of success established, the psychologist must select tests that will reliably measure abilities or traits important in successful performance. Once tests have been chosen for tryout, they must be validated on present or new employees and must differentiate between good and poor workers. With new employees, tests are administered at the time of hiring but are not utilized in the selection decision. Then at some later time test scores are correlated with performance ratings to determine how successfully tests would have screened out poor performers. If tests are validated on present employees, the extent to which they can be applied to applicants with little or no experience should be seriously considered. A test battery must be cross-validated on a second and even a third group before it can be used with confidence in making predictions.

***Can results be misinterpreted by a trained tester?***

No one is infallible but a trained tester is expected to be familiar with the following properties and limitations of tests when making predictions about present or future job performance:

A test used for selection in one situation may not be effective in another situation where working conditions, job demands, worker characteristics, and level of morale are entirely different.

A test score does not represent a point on a scale but rather a range of values.

Test norms or standards used should be appropriate for the individuals tested with respect to age, sex, education, and experience.

Procedures for administering and scoring tests must be strictly adhered to if predictions are to be valid.

A high score on a test does not necessarily mean a good performance on the job. For example, an individual with a high score on an intelligence test may not adjust to routine clerical work and may actually do poorly because the work offers no challenge.

Tests cannot sample all aspects of behavior important in job success nor is it always known what minimal levels of skill are acceptable for satisfactory performance.

***What factors other than those inherent in the nature of the vocational tests themselves must be controlled if test results are to be valid?***

Attention should be paid to the physical setting in which tests are to be administered such as the availability of a quiet room, ample space for comfortable writing, good lighting, and proper ventilation. An objective point of view, yet friendly and permissive attitude, on the part of the examiner is important. Instructions must be heard and understood. Disrupting factors such as anxiety must be recognized and cognizance should be taken of motivational factors.

***Can aptitude and vocational testing ever be used to find psychological disorders?***

Yes. Though not administered for the purpose of revealing pathological signs, which is the province of clinical testing, vocational tests can shed light on an individual's work habits, his attitudes toward others as well as toward himself. Psychologists are aware of the importance of observing as well as of measuring a person's behavior, and look for peculiar mannerisms, motor difficulties, irritability, impatience, explosive emotionality, lack of self-confidence, readiness to give up easily, low energy level, confusion, bizarre thinking, inability to follow instructions, and the like.

***Has the cumulative knowledge of aptitude and vocational testing affected schooling, working conditions, better placement of an individual in a job?***

Very definitely. Investigations have disclosed that where tests have been used intelligently to select candidates for training both in schools and in industry, fewer failures have resulted than in situations where

tests have been omitted from consideration. Since training may be a costly matter, amounting to hundreds and even thousands of dollars for a single individual, any tool that can reduce costs, even slightly, is a welcome addition to the selection procedure. Failure has adverse emotional effects on individuals in addition to contributing to a waste of time, money, and energy.

When students have been admitted to courses on the basis of tests, their higher level of ability and aptitude permits the teacher to concentrate on the more challenging aspects of the course than would otherwise be possible with a more heterogeneous group of students. This not only makes for more interesting class sessions, but also facilitates progress in the course.

Satisfactory placement on the job contributes to overall adjustment. A man who is happy with his work, who can perform assignments well and feels that he is making a contribution to the social economy, is less likely to be a problem employee burdened with grievances and displaying a hostile attitude toward his associates. Employee satisfaction strengthens the level of morale within the plant, facilitates good employee-employer relationships, and contributes to greater production and efficiency.



# BIOLOGICAL FACTORS IN MENTAL ILLNESS

by SEYMOUR S. KETY, M.D.

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***There seems to be a great deal of current enthusiasm regarding the biological basis of mental illness. Is this a new idea?***

This is not a new idea. In ancient Greece the Hippocratic physicians attributed mental illness to changes in the state of the brain, and one of the best statements of the current interest in biochemical theories of mental illness was made in 1884 by J. L. W. Thudichum, who stated that just as alcohol produced mental disturbances by the action of a poison from without, it was quite likely that other mental disturbances were produced by chemical poison produced within the body.

***What progress has been made in demonstrating biological bases for some of the mental illnesses?***

A significant number of mental illnesses have been shown to be the result of organic changes in the brain or in the body. There has not been as clear-cut a demonstration of the operation of psychosocial or psychodynamic principles even in those areas to which they are pertinent, although it must be remembered that interest in the latter disciplines has been neither as extensive nor as prolonged.

***What are some of the mental disorders that have clearly been shown to be caused by biological factors?***

General paresis was until quite recently an important mental disorder that accounted for a large proportion of the hospitalized mentally ill. Fifty years ago it was shown to be the result of the invasion of the brain by the spirochete that caused syphilis. Modern treatment of syphilitic infection by means of antibiotics has made general paresis extremely rare.

Pellagra is a nutritional disease that has important mental disturbances associated with it. A generation ago it accounted for a significant percentage of institutionalized mental disorders. Thirty-five years ago pellagra was shown to result from a dietary lack of one of the B vitamins (nicotinic acid). The use of this agent as a dietary supplement

will prevent the occurrence of pellagra and cause the reversal of its physical and mental symptoms.

Certain genetic forms of mental retardation have been shown to be associated with biochemical abnormalities that result from the absence of specific enzymes. *Phenylketonuria* and *galactosemia* are two examples, each characterized by an inability to metabolize properly a normal constituent of the diet. Some progress has been made in the prevention or amelioration of symptoms in these disorders by the use of special diets.

A large number of metabolic or medical disorders that have their origin elsewhere in the body are accompanied by serious mental alterations. Among these are certain thyroid disorders, certain cases of heart failure, and an inborn error of metabolism known as *porphyria*. A large number of drugs and of industrial poisons are capable of producing mental changes many of which are easily confused with other forms of mental illness. Mercury and certain of the organic solvents are among the industrial hazards, while the list of drugs is quite long, including especially: bromides, amphetamine, cortisone, iproniazid and the barbiturates. (See *Psychopharmacology*)

*To what extent is it likely that biological factors play a role in the major psychoses? What about senile psychosis?*

The brains of patients with senile psychosis show, after death, certain pathological changes, such as arteriosclerosis of the vessels, atrophy of the brain substance, and loss of neurones, which appear to be more severe than similar changes that occur in elderly but non-psychotic individuals. Recently there has been shown to be a good correlation between psychological deficit or mental inadequacy and a reduction in the supply of blood to the brain and its utilization of oxygen during life. Even though such biological changes may account for a large proportion of senile psychoses, they do not preclude the operation of powerful social and emotional problems associated with aging as necessary or important to the development of the psychoses of senility. (See *The Senile Psychoses*)

*What about the operation of biological factors in an affective psychosis, such as depression?*

The evidence here is much more inferential. A pathological or biochemical lesion has not been demonstrated to be a causative factor in depression. On the other hand, certain findings and features of this disorder suggest the possibility that biological factors may play an im-

portant role. Alterations in the excretion of certain hormones of the adrenal cortex have been reported although it is not clear whether these are primary or secondary to the depression.

The drug reserpine will produce a state that is indistinguishable from clinical depression in a small percentage of people who take this drug for some medical problem such as hypertension. Electroshock therapy or certain antidepressant drugs will often produce a prompt amelioration of symptoms in depressed patients. It is interesting that reserpine, on the one hand, and many of the antidepressant drugs on the other, affect brain amines in opposite ways, reserpine causing the depletion of the substances and the antidepressants causing their accumulation in the brain. On that basis it has been tempting to speculate that depression may in some way be related to alterations in the amines that occur in the brain and for which no definite function has yet been found. Further investigation is required of that hypothesis, as well as the hypotheses that involve psychosocial factors, in order to determine to what extent they are valid and how they may be inter-related in different forms of depression. (See *Depressions*)

***What biological factors have been shown to be important in schizophrenia?***

The answer to this question conveys a series of interesting findings, enthusiastic hopes followed by disappointment. At the turn of the century some of the great neuropathologists of their time reported a number of pathological lesions in the brains of schizophrenic patients. Twenty years later it was pointed out that these same lesions are found in the brains of the population generally and are not characteristic of schizophrenia. At the present time the consensus of neuropathologists is that there is no characteristic lesion that has been demonstrated in the brain in schizophrenia. Similarly there is no agreement among biological psychiatrists that a biochemical lesion has been discovered in this disorder. In one area, that of electroencephalography, it is generally accepted that a considerable proportion of schizophrenic patients show abnormalities in their brain wave patterns, although the types of abnormality are quite variable and no single characteristic change is found. (See *Schizophrenia*)

***What about newspaper reports of the discovery of biochemical tests for schizophrenia?***

Many such tests have been reported over the past thirty years. In each case further study has failed to demonstrate that the test was valid

or that the basis of the test was a necessary feature of even a segment of schizophrenic patients.

***How does one account for the large number of unconfirmed biochemical findings in research in schizophrenia?***

It is extremely difficult to perform valid biochemical studies in schizophrenia because of the presence in this condition of a large number of variables that are difficult to control and are more the result of the schizophrenia or how it is managed than they are characteristic or causal of the disorder.

***What are some examples of such pitfalls?***

In the first place, there is no evidence that schizophrenia is a single disorder with a common cause. On the contrary, the evidence suggests that schizophrenia is a complex of psychological symptoms that may arise from a large variety of causes. This would suggest that it is not likely that a single biochemical test will be discovered for all cases of schizophrenia.

The average chronic schizophrenic has spent ten to twenty or more years in a mental institution and has been subjected to many of the rigors and deprivations that are characteristic of most such institutions. The diet is often inadequate and a number of vitamin deficiencies have been found in schizophrenic patients that, although they produce biochemically detectable changes in the blood or urine, are accountable in terms of the dietary inadequacy and are correctable by means of vitamin supplements without affecting the mental state. Recently two tests for schizophrenia have been shown to depend upon a low level of vitamin C in the body caused by a deficiency of that vitamin in the diet, and not caused at all by schizophrenia.

Most psychiatric patients, nowadays, have been given a number of the newer drugs before they are admitted to a mental institution. These drugs have products that persist in the body and appear in the blood or urine for weeks after they have been discontinued. In some instances chemical tests have really been measuring these drug products rather than a fundamental change in the disorder.

Because the standards of hygiene are difficult to maintain in an overcrowded population, there is a high incidence of various forms of infection, especially of the liver, in the inmates of mental institutions. A number of the biochemical tests for schizophrenia are similar to

changes in acute or chronic liver disease, which could result from hepatitis, a possibility that has not been ruled out.

Chronic inmates of mental institutions are not exposed to the opportunities or the necessities for physical activity or exercise that occurs in the noninstitutionalized population. As a result such patients are usually not as physically fit as have been the normal controls with whom they have been compared. Errors due to this effect of chronic institutionalization have not usually been ruled out in biochemical tests.

*What are some of the better known hypotheses prevalent today that suggest a biochemical basis for schizophrenia?*

In hypoxic states, that is, conditions of oxygen deprivation as in sudden exposure to high altitudes, certain vague mental disturbances occur that are somewhat suggestive of schizophrenia. This has led to the hypothesis that in that latter condition there is an interference with the oxygen supply or its utilization in the brain. Measurements of these two functions that have been made in the past fifteen years do not reveal any decrease for the brain as a whole in schizophrenia. The possibility of a local interference somewhere within the brain remains, although there is little direct evidence to support it.

There has been considerable interest in protein metabolism in schizophrenia. More than twenty years ago a Norwegian psychiatrist reported evidence of a change in protein metabolism that coincided with changes in the symptomatology in patients with a rare periodic form of schizophrenia. The building blocks of protein are the amino acids, which are absorbed in the process of digestion from the gastrointestinal tract and metabolized by the body through a number of individual pathways. These amino acids and the proteins that are formed from them within the body are vital to the structure and function of every organ, including the brain. Although there has been considerable speculation regarding disturbances in the metabolism of one or another amino acid in schizophrenia, none of these possibilities has been established at the present time.

An interesting group of substances that are derived from amino acids are the amines. Most amino acids are capable of producing several such amines, some of which have important physiological effects in the body. A number of these, notably serotonin, norepinephrine, glutamine, histamine, occur in the brain in rather high concentration and are in especially high concentration in certain areas that are probably related to the mediation of emotional states. There have been a number of

reports of the finding, in blood or urine of schizophrenic patients, of amines or their products in abnormal concentration or of abnormal type. Many of these findings have recently been shown to be related to dietary variables, such as the excessive drinking of coffee, or the ingestion of certain foods that are high in special amines. None of these findings has yet been clearly demonstrated to be characteristic of the schizophrenic process.

***Is there evidence for an abnormality in epinephrine or adrenalin metabolism in schizophrenia?***

Mescaline, the active ingredient of peyote, is capable of producing an acute hallucinatory psychosis when administered to volunteers. This psychosis resembles schizophrenia in certain features, and mescaline resembles adrenalin in its chemical structure. This led to the interesting speculation that in schizophrenia there was a disturbance of the metabolism of the amine epinephrine or adrenalin, an important hormone put out by the adrenal gland in situations of stress. It was hypothesized that in such patients adrenalin was converted to abnormal metabolites, like mescaline, that were also capable of producing hallucinations and causing other symptoms of schizophrenia. Although some evidence has been gathered in support of the hypothesis, recent studies with radioactive adrenalin have shown that the metabolism of this hormone in schizophrenic patients is not significantly different from its metabolism in normal controls, so that at the present time this remains an unproven hypothesis.

***Is there evidence that serotonin plays a role in schizophrenia?***

In 1943 it was discovered that a newly synthesized substance, lysergic acid diethylamide or L.S.D., in extremely small doses could produce a hallucinatory psychosis in normal individuals. Some years later it was found that this substance, in very small concentrations, could block the effect of serotonin on smooth muscle. Inasmuch as it was known that serotonin occurred in the brain, it was tempting to speculate that perhaps L.S.D. produced its psychosis by blocking the serotonin in the brain and further that perhaps a naturally occurring psychosis like schizophrenia could be the result of a deficiency of that amine in the brain. Although a certain amount of indirect evidence has been adduced in support of that hypothesis, a derangement in the metabolism of serotonin in schizophrenia has not been unequivocally demonstrated.

***Are there abnormal proteins in the blood of schizophrenic patients?***

There have been a number of reports in recent years that the blood of some or most schizophrenic patients has properties different from that of normal blood when tested in another human being, animal, or animal preparation. For example, it was reported from Tulane University of Louisiana that a substance (taraxein) could be extracted from the blood of schizophrenic patients, which, when injected into prisoner volunteers, produced symptoms suggestive of some of those seen in schizophrenia. A group at Washington University that attempted to replicate that experiment was not able to do so.

More recently it has been reported that the serum of schizophrenic patients when injected into rats slows the performance of these animals in certain tasks. A group at Wayne State University has reported that the plasma of schizophrenic patients alters the metabolism of red blood cells suspended in it in a way that does not occur in normal plasma. Findings have been reported from Russia and later from the United States indicating the ability to sensitize guinea pigs to substances that are present in the blood of schizophrenic patients and that apparently are not present in most normal individuals. Where attempts have been made to identify further the substances responsible for each of the effects described above, evidence has been adduced that they are protein. Attempts are being made to purify and isolate the responsible proteins but as yet they have been demonstrated only by their effects upon the living systems described. It has not yet been possible to produce convincing evidence that the substance or substances involved are characteristic for schizophrenia.

***Are there compelling reasons for believing that a search for biochemical factors in schizophrenia is worthwhile?***

A number of studies of the role of genetic factors in schizophrenia make it difficult to avoid the conclusion that such factors play an important role in many forms of schizophrenia, although there is equally good evidence that genetic factors are not a sufficient explanation and that other influences are required. To the extent that genetics operates in producing schizophrenia, it operates through biochemical mechanisms, although it is not necessarily true that such mechanisms would reveal themselves in studies on blood or urine. It is not logical to infer that, because biological factors have been demonstrated to operate significantly in other forms of mental illness, similar mechanisms must operate in all mental disorder. It is equally illogical to conclude that,

because a biochemical or biological defect has not yet been demonstrated in schizophrenia despite a great deal of effort, it does not exist. There does not seem to be a basis for either great optimism or undue pessimism with regard to this approach, and it seems most appropriate that hypotheses along these lines should continue to be developed and tested with all the resources that are available, but with an awareness of the pitfalls and the importance of adequate controls.



# BRAIN DAMAGE

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## ***How can the brain be damaged?***

There is no limit to the variety of methods that an industrial culture such as ours can devise to inflict injury on the "most important thing"—the brain. Modern man's genius has developed high-speed projectiles that can, and often do, perforate the skull; the automobile provides a high daily toll of brain-injured victims; sports, with an ever-broadening circle of participants, contribute a further substantial share of brain cripples. In addition to injury by physical force, the brain can be damaged by disease such as tumor and infection; also by ionizing radiations, heatstroke, chemicals, etc.

## ***What is trauma?***

Trauma is an injury or shock. Usually the term implies some violent physical or psychological force.

## ***What is coma?***

Coma is profound unconsciousness.

## ***What is delirium?***

Delirium is a disturbed mental state characterized by disorientation, confusion, agitation, and often, hallucinations. It may be due to a variety of causes, including poisons, fever, etc.

## ***What is a concussion?***

A concussion is the mildest degree of head injury. It is assumed to be due to the shaking up of the brain without causing any permanent structural or biochemical damage. It is usually associated with brief unconsciousness. One of the factors in concussion is the sudden increase in intracranial pressure, which some authorities believe causes unconsciousness by compressing the brain stem rather than by damage to the

surface of the brain. Concussion may or may not be associated with the more severe forms of head injury, such as contusion (bruising) and laceration (tearing) of the brain.

***How does physical force damage the brain?***

This varies depending on the strength, direction, and nature of the impact. In general, two types of head injuries are recognized:

1) Penetrating (when an object enters the cranial cavity damaging the contents).

2) Closed head injury (an injury in which there is no fracture nor entrance of a foreign object into the skull).

The latter type of injury usually results from sudden acceleration or deceleration of the head. In such instances the brain is compressed against the unyielding bony skull and thus damaged. For example, in a head-on collision of autos, the passenger seated next to the driver is thrown forward, his head striking the windshield. Even though his skull may not be fractured, the sudden deceleration of the skull causes the semisolid brain to continue the forward motion and smash itself against the inside of the skull. This type of injury is often serious or fatal.

The brain can be damaged also by deformation, which can be the result of compression caused by a strong force that is slowly exerted against the skull. For example, deformity of the brain of the infant may occur during delivery through a narrowed maternal pelvis.

***Can a mild blow to the head cause brain damage? Of what is the damage likely to consist?***

Usually a mild blow causes no damage although mild concussion—shaking up of the brain—may ensue. In such instances there may be some swelling (which is reversible) of the individual cells and of the brain tissue, and there may be transient symptoms such as headache, nausea, vomiting, and perhaps some blurring of vision.

***Are some individuals more susceptible to brain damage than others? If so, why? Are there physical reasons? Psychological reasons?***

Susceptibility to brain damage can be due to either physical or psychological reasons. The physical reasons include several mechanisms. Certain types of brain damage are more likely to occur in the very young, that is, in infancy, and in the very old. The common denominator in these two extremes of age is the lack of structural support that

the very young or the very old brain provides for the blood vessels that bridge the subdural space. (The subdural space is a narrow slit across which these veins run through the thick covering of the brain—the dura.) They run roughly in a direction perpendicular to the brain so that a blow directed to the front or the back of the head causes a shearing force that may tear bridging veins and cause serious, often fatal, subdural bleeding. The newborn infant is sometimes a victim of this process. Similarly, a relatively trivial blow to the front or back of the head of an elderly patient whose brain atrophy (deterioration) has left these bridging veins poorly supported, can cause bleeding that compresses the brain in a manner identical to a rapidly growing tumor. If not diagnosed and treated in time, the outcome is almost always fatal.

Often the alcoholic patient has brain atrophy and, in addition, his blood-clotting mechanisms are impaired because of associated liver damage, placing him in double jeopardy from a head injury.

The psychological reasons for vulnerability to head injury are innumerable. Some subjects are uniquely vulnerable to the effects of brain damage. Trivial injury in a dependent, inadequate person may represent to him the long-awaited, face-saving opportunity to withdraw from the competitive events of life, to exploit his alleged infirmity by manipulating the environment, and perhaps encourage him to retaliate against his more successful contemporaries. The person may even tyrannize his family and friends with his invalidism.

Any illness or infirmity invokes sympathy and patience for the victim, but injury to the delicate and vital brain customarily invokes the maximum in concern and solicitude.

Many people carefully and deliberately analyze and appraise the potential benefits of capitalizing on a head injury. Of course, this is malingering (feigning illness) and, if detected, derision and ridicule may be its eventual reward. But the risk may be worth taking, and often is, if for no other reason than that monetary award often awaits the successful deceiver. Litigation stemming from auto accidents represents about 75 per cent of all cases heard in metropolitan courts in this country. The alleged effects of head injuries constitute a substantial segment of these personal liability cases. To resolve them fairly, poses a vexatious legal and medical problem.

There are other types of individuals, including those who unconsciously elaborate the consequences of their head injuries, and those who partly consciously and partly nonconsciously embellish or prolong

their posttraumatic complaints. Identification of these two contrasting psychological patterns of motivation is not always easy.

***Is there much incidence of brain damage at birth?***

One in every sixteen babies born in the United States suffers from some form of nervous system disability. These disabilities can be caused by instruments, anesthetics, drugs, lack of oxygen as well as by excessive oxygen, improperly balanced diet in the mother, incompatibility of blood types, infection in the mother, and genetic factors.

***What effects can brain damage have on the individual? Physically? Psychologically?***

Part of this question has been answered previously. Physically, the results of brain damage may range from something inconsequential to the total disability of the victim. Paralysis of limbs, blindness, deafness, and convulsions are some of the physical consequences of brain damage.

The subject of psychological effects of head injury is complicated and controversial. The symptoms most commonly recorded as manifestations of concussion include fatigue, impaired memory, headache, dizziness, and change in personality. Depression, insomnia, and irritability are other symptoms. These complaints, which occur more often in women, usually follow a concussion rather than major cerebral damage and are influenced by the patient's anxiety. The prospect of compensation influences the severity and duration of postconcussive disorders.

Severe head injury can produce a train of psychological consequences, especially if there has been prolonged posttraumatic coma. These symptoms include impairment of intellectual function, poor reasoning, defective abstract thinking, distractibility, inability to persevere at a task, etc. Mood changes also may occur; these include inappropriate hilarity, irritability, and mood swings. Unmistakable psychosis can be, but rarely is, produced by trauma of the brain.

***What is the condition of a punch-drunk prizefighter?***

This condition is an occupational hazard of professional boxers and results from multiple blows to the head that produce many small hemorrhages throughout the brain tissue both in and around the cortex and also in the deeper structures. Atrophy of the brain might ensue, associated with impoverishment of intellectual powers, including defective memory, lethargy, and impaired judgment. Motor manifesta-

tions occur also, including rigidity, an expressionless face, and tremor. Convulsions and impaired vision are further consequences of brain damage resulting from this dangerous sport.

***Does alcohol damage the brain? How? Can this damage be repaired?***

Alcohol damages the brain in several ways: by its direct toxic effect on the cells, by producing swelling of the brain, and by vitamin deprivation. The effects of acute alcoholic intoxication, including the brain swelling, are reversible, but with repeated injury through alcohol, there is actual loss of brain cells and substance, shrinkage, and scarring of the brain, all of which are irreparable.

***Can the brain be damaged by overactivity, lack of rest, stress, or psychological states?***

No. So long as the patient receives adequate water and nourishment, it is improbable that the above factors would cause brain damage.

***Can brain damage go undetected for a period of time?***

Yes. Brain damage can, and frequently does, go undetected especially when caused by brain tumors, subdural hematoma (a tumorlike swelling containing blood), and some toxic metabolic states (poisonous conditions in the body). Because the symptoms can be misconstrued as manifestations of a neurosis or some other mental disorder, the exact diagnosis can be delayed or missed completely.

***What are the signs of brain damage?***

In general, mental symptoms alone may be the early or sole manifestation of brain damage, or such damage may be associated with blindness, deafness, anosmia (loss of sense of smell), aphasia (loss of ability to pronounce words), paralysis, convulsions, tremor, etc.

***Can damaged brain tissue be restored or repaired?***

Brain tissue, that is, ganglion cells, cannot be repaired or replaced. They cannot regenerate as some other tissues in the body can.

***Does the brain have any mechanism for remedying damage done to it?***

The brain is relatively sensitive to damage once it has occurred. It is protected by the bony skull and by the overlying water jacket of spinal fluid in addition to the three layers of tissue covering it.

However, once damage has been done to brain cells, restitution of the impaired function can come about by gradual resolution of the edema (excessive accumulation of fluid in the tissue spaces), which may be absorbed by the local blood supply. There can be considerable physiologic recovery—as from spinal shock—which is not dependent on known morphological changes. But other processes are not reversible.

***What treatments are available for brain damage?***

These treatments are largely symptomatic, that is, they rehabilitate the patient by assisting him in the use of whatever of his facilities are left. For example, a paralyzed arm may be made more useful by some artificial device. Physical therapy and speech therapy for the aphasic patient are other therapeutic measures.

***What has been the success of these treatments? On what does this depend?***

Treating and rehabilitating the brain-damaged patient is one of the most gratifying achievements in modern medical science. The prime movers in this program have been the Veterans Administration hospitals, which in the postwar period have emptied hundreds of beds previously occupied by neurological cripples. Entire wards have been converted to other sorely needed bed space. This was accomplished by teams of therapists, which included physiatrists (specialists in physical medicine), neurologists, orthopedists, occupational therapists, speech therapists, psychologists, etc.

The success of treatment depends in a large measure on the industry and competence of the medical team but also on the motivation of the patient. Merely ambulating the patient may improve his morale and energize him to further efforts that in many instances restore him to complete self-sufficiency.

In recent years surgical techniques have evolved for treatment of certain motor disorders. These offer considerable promise of help for certain types of neuromuscular disabilities.

***Are new measures being developed to avert brain damage at birth?***

The problem of brain damage at birth has been attacked on a broad front. The National Institute of Health has organized a detailed study of fifty thousand pregnancies over a ten-year period. Some ten thousand mothers and their newborn babies will be studied each year

for the first five years by specialists in many different medical disciplines: obstetrics, pediatrics, neurology, etc. This project has already produced important results. Instruments have been devised to detect impaired oxygen supply to the fetus, thus preventing irreparable brain damage. Newer knowledge in other fields is decreasing damage at birth, including knowledge of blood chemistry, Rh blood factors, placental infections, etc. Newer anesthetics and anesthetic techniques have been developed, and metabolic disorders in the mother are now recognized as treatable in many instances, thus preventing possible brain damage to the developing fetus.

# BRAIN DISORDERS, ORGANIC

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## ***What are organic brain disorders?***

These are structural or chemical (organic) derangements of the brain sometimes resulting in a wide variety of manifestations, which may simulate disorders caused by mental or psychic factors, and which must be distinguished from them. The psychogenic disorders, by contrast with the organic ones, are not associated with any demonstrable damage or defect. The term *organic* clearly means physical, that is, structural or chemical, even though such defects may not necessarily be demonstrable in all cases by present-day techniques.

## ***What are the causes of organic brain disorders?***

There are many possible causes; some clearly understood, others obscure. A convenient brief classification of organic brain disorders follows:

### **A. CONGENITAL, PRENATAL, OR DEVELOPMENTAL DEFECTS OR DISORDERS**

The underlying mechanism in this category is not known although it is generally recognized that genetic factors may operate. Intrauterine influences often play an important role since the central nervous system of the embryo is uniquely susceptible to damage by infections in the mother, by ionizing radiations, etc. In fact, anything causing anoxia (inadequate oxygen supply) to the fetus may impair the complex sequential organization of fetal developments. The central nervous system irregularities may be associated with skeletal defects as will a defect in other organs. Examples of these congenital defects or malformations are cerebral palsy, which is due to failure of development or to brain damage during or immediately after birth, hydrocephalus (too much fluid within the skull), microcephaly (unusual smallness of the head), mental retardation, etc.

Genetic influences often combine with environmental ones to cause a congenital defect. Rapid advances are being made in this field, espe-



cially in research on irregularities of the chromosomes which may be one of the causes of mongolism. Although this may occur by accident, this accident is facilitated by, if not strictly caused by, the advanced age of the mother; but this may also occur in younger mothers.

## B. DEGENERATIVE DISEASES

Some of these can be inherited; for example, Huntington's chorea, which is a progressive atrophy of the brain associated with severe dementia (organic loss of intellectual function) and bizarre involuntary movements of the extremities and trunk. The mental symptoms may precede the neurological manifestations, but both are progressive. There is no treatment. Other examples of degenerative disease include multiple sclerosis, amyotrophic lateral sclerosis, progressive muscular atrophy, etc. In these diseases there is loss of the cells in the brain or in the spinal cord.

## C. INFECTIONS OF THE CENTRAL NERVOUS SYSTEM

Any viral, bacterial, or parasitic agent may invade the brain and cause either temporary or permanent damage or death.

1. Viruses frequently invade the brain and cause an encephalitis (an inflammation of the brain, which may be devastating); for example, rabies, encephalitis lethargica (sleeping sickness), poliomyelitis, infectious mononucleosis, Coxsackie disease, etc. Also the common childhood diseases such as mumps, measles, and chicken pox may cause an encephalitis resulting from invasion of the brain by the offending virus.

2. Bacterial diseases are frequently responsible for brain infections. Such diseases include syphilis of the brain ( paresis); tuberculous and other forms of bacterial meningitis; brain abscess; thrombophlebitis; etc.

3. Rickettsial diseases; for example, Rocky Mountain spotted fever, typhus, etc., occasionally affect the brain.

4. Parasitic infestation of the brain may occur, for example, due to malaria, amebiasis, and worms. The latter would include trichinosis (contracted by eating undercooked pork), schistosomiasis (blood flukes), and Echinococcus (tapeworm). About fifteen per cent of the cases of trichinosis involve the brain, manifested by convulsions, delirium, and focal neurological disease. Malaria and attacks of toxoplasmosis are protozoan diseases caused by parasites that invade the nervous system. Toxoplasmosis is due to the organism, toxoplasma, which usually invades the fetus in the uterus and often attacks the brain and eye, caus-

ing encephalitis and retinitis. Convulsions, blindness, and congenital malformations are common manifestations. The mother may appear perfectly healthy.

5. Fungi and molds are recognized with increasing frequency as causative agents in meningitis and encephalitis.

#### **D. TOXIC METABOLIC DISORDERS**

These embrace a very wide area of causation of organic brain disease. New diseases in this category are being added at an accelerated rate.

Toxins range from rare agents found only in the scientist's laboratory to common household items such as insecticides and carbon tetrachloride. The latter is a particularly dangerous agent, and any noticeable odor of it indicates that there is a toxic level of concentration in the surrounding atmosphere. In such circumstances, damage to a person's central nervous system may be severe and, if exposure takes place during the drinking of alcohol, results are often fatal.

Many toxins may be absorbed by ingestion, inhalation, and absorption through the skin, or by all three processes. Lead is an example of such a poison. Poisoning due to lead usually occurs in children and is more often due to eating paint from toys or furniture. It is manifested by convulsions and other neurological signs, including paralysis, blindness, rigidity, and stupor.

Solvents and organic compounds may be responsible for acute or chronic intoxication. The commonest of all toxins is alcohol. Repeated consumption causes degenerative changes in the central and peripheral nervous system with extensive atrophy of the brain and loss of ganglion cells of the cortex. This causes a diversity of organic brain patterns, including permanent dementia, ataxia, and blindness. The associated liver damage due also to alcohol imposes further metabolic dysfunction on the structural brain damage, by derangement of the normal oxidative mechanisms of the brain. "Liver" coma and psychiatric symptoms may reflect this toxic metabolic liver-brain disturbance.

Methyl alcohol (wood alcohol) is even more dangerous than ethyl alcohol (grain alcohol) since as little as three teaspoonfuls may cause serious brain damage.

In addition, poisoning by drugs such as barbiturates, bromides, tranquilizers, antihistamines, hypotensives (drugs for treatment of low blood pressure), etc., may cause organic brain conditions in which behavioral and neurological manifestations may be varied, bizarre, and transitory, and may mislead the most astute clinician. For example, belladonna

and similar synthetic preparations used for peptic ulcers and a variety of other disorders, may cause hallucinations; reserpine and similar derivatives may cause deep depressions; bromides may cause impaired memory, confusion, and psychosis. Some of these drug reactions reflect overdosage, but in some patients an inherent sensitivity may result in an inordinate response. The aging are particularly unpredictable in their response to many drugs.

#### E. TUMOR

Brain tumor may cause an infinite variety and combination of mental and neurological symptoms and these are discussed more fully under brain tumor.

#### F. TRAUMA

Trauma, a physical force applied directly or indirectly to the brain, is a very common cause of organic brain syndromes. These may be mild, moderate, or severe, and may be permanent or transient.

#### G. METABOLIC DISORDERS

Metabolic derangements as a cause of brain disorder have been carefully investigated recently through multiple approaches, including the genetic. Newer disorders, some of them treatable, have been identified:

1. Galactosemia is a rare, hereditary, inborn error of metabolism in which glucose, which is indispensable for normal brain function, is made unavailable. Convulsions, mental retardation, and blindness result unless dietary treatment is instituted early in infancy.

2. Hypoglycemia (too little sugar in the blood), which occurs in certain families, may result in irreparable brain damage if not treated early. In this condition the blood sugar periodically drops to low levels, sometimes induced by eating certain proteins from which the patient must be protected by dietary and other treatment.

3. Phenylketonuria, which presumably is inherited as a Mendelian recessive characteristic, results in mental deficiency in a high proportion of cases, if not in all instances. This defect is due to inability to metabolize a specific amino acid, phenylalanine. A simple sensitive urine test readily identifies this entity, and now is being employed routinely, in many centers, for all mentally retarded children. Diets low in phenylalanine, if instituted early, may prevent irreparable brain damage.

4. Porphyria is a mysterious disease that often declares itself with mental symptoms, including psychotic manifestations. Often the patients are hospitalized with the erroneous diagnosis of schizophrenia.

Periodic abdominal pain, pigmentation of the skin, and red urine are other manifestations. In many cases, genetic factors evidently play a role. Porphyrins are chemical substances which are ubiquitous in nature, and disturbance of their metabolism is responsible for this disorder.

Other metabolic disorders, including acquired ones, may cause organic brain disease. The commonest of such disorders is diabetes. Pernicious anemia often is reflected early in mental manifestations that frequently respond to appropriate therapy. If untreated, death results.

#### **H. VASCULAR DISEASE OF THE BRAIN**

Disease of the blood vessels is one of the commonest causes of organic brain disorders, and is discussed further under strokes.

##### ***What are the manifestations of organic brain disorders?***

These may be varied and the diagnosis may be elusive especially since mental symptoms often are isolated and often are the earliest and the preponderant manifestations. Change of personality may be the only reflection of a progressive organic brain disease. This may be manifested by deterioration of habits of personal hygiene, indifference, irritability, and suspiciousness. In addition, impaired memory, distractibility and lack of concentration often occur. During the progress of the disease, headache, disorientation, confusion, and coma may occur. Convulsions are common, too.

##### ***What are hallucinations?***

Hallucinations and delusions may occur as a result of organic brain disorders. Olfactory (smell) or gustatory (taste) hallucinations, which are interpreted usually as symptoms of schizophrenia actually may reflect a lesion (morbid change in tissue structure) of the temporal lobe of the brain. Focal weakness and other neurological signs may be indications of organic brain disease, and are often due to a tumor.

##### ***What is a brain tumor?***

This term is used in a generic and also in a specific sense. It usually implies a localized, expanding, intracranial lesion, which by occupying space within the skull causes a displacement or replacement of brain tissue and also causes a rise in intracranial pressure. Thus, both a blood clot and an abscess, in a generic sense, are tumors.

Tumors can be further subdivided into benign and malignant. All metastatic tumors are malignant, and a very high proportion of primary

brain tumors are malignant. The nonmalignant (benign) tumors in many instances are treatable by surgical excision.

The term tumor usually is used in its more restricted sense, that is, of a neoplasm (new growth). About half of these are due to metastatic tumors, that is, those that originate from some more or less remote organ and are carried by the bloodstream to the brain, where they lodge and grow. The other half are due to primary tumors, that is, tumors that originate in the tissue of the brain itself.

### *What is a stroke?*

The term stroke covers a broad category of causation of sudden paralysis. It can be divided into: (1) the acute apoplectic stroke; (2) the subsequent paralysis. The former may occur quite suddenly, with the patient collapsing or becoming unconscious. Headache, dizziness, confusion, or pins-and-needles feeling may precede the acute onset. The paralytic stage is usually represented by more or less complete paralysis on one side of the body. Although tumors or other brain lesions may cause a stroke, cerebrovascular lesions are by far the commonest cause of either generalized or focal disease of the brain.

Three general underlying causes of stroke are hemorrhage, thrombosis, and embolism. The first is usually due to rupture of an arteriosclerotic vessel (an artery with thickened walls) in the brain. An aneurysm, that is, a localized area of weakness in the wall of a blood vessel, may rupture and suddenly release a large volume of blood into the brain causing destruction of the contiguous tissue.

Cerebral thrombosis is the commonest cause of stroke, and the common cause of cerebral thrombosis is arteriosclerosis. The thrombosis—the closure of a vessel—may be sudden or gradual, but in either event, the area nourished by the vessel is destroyed and paralysis and other neurological manifestations result. The closure of a vessel is due to clotting of the blood at the site of a roughened area on the inside of the vessel wall. Swelling of the brain occurs as an immediate result, but this edema (swelling caused by excessive amount of fluid) may be reversible, and the patient's signs and symptoms may recede partially or completely, depending upon the size of the vessel, the site, and the collateral circulation.

Embolism—the closure of a cerebral vessel by particulate (composed of particles) matter such as a blood clot, tumor, bacteria, etc., originating from a remote site—is the least common cause of stroke. It is frequently associated with heart disease.

The peak incidence of stroke is between the ages of forty and eighty, but strokes may also occur in young people, including children. If the stroke is in the dominant hemisphere of the brain (in the left hemisphere in most people), aphasia—loss of ability to pronounce words—may result. This is a disturbance in speech that may require specialized treatment, with particular attention to the psychological consequences of this impairment. Speech therapy may be of considerable help in rehabilitating the patient. Physiotherapy is often a help in restoring power and dexterity to the weakened limbs. Many patients who have had strokes are restored to full self-sufficiency.

### ***What is epilepsy?***

This is a common neurological disorder associated with recurring excessive, electrical discharge emanating from a group of brain cells and manifested by periodic and transitory disturbance in the function of the brain. The epileptic attack usually occurs abruptly, ceases spontaneously, but frequently recurs. It is characterized usually by sudden loss of consciousness, followed by focal or generalized rhythmic shaking of the limbs. The latter is typical of so-called grand mal epilepsy, but there are two other types: petit mal, which is a very brief lapse of consciousness sometimes associated with dropping of the head or batting of the eyelids; and psychomotor epilepsy, which is manifested by performance of automatic but often well-coordinated, complicated acts during which the patient is unconscious. He has no memory of the attacks which are frequently stereotyped and preceded by the same aura or warning each time. Psychological manifestations are common, particularly in this latter form of epilepsy. Epilepsy may manifest itself in many ways, depending upon which part of the brain is involved and what the basic causative agent is. Thus, epilepsy is a symptom rather than a disease. The neurological examination is often negative but the electroencephalogram is invaluable in establishing the diagnosis. Effective therapy is usually available. (See *Epilepsy and Other Paroxysmal Disorders*)

### ***What is cerebral palsy?***

Cerebral palsy is not a disease entity; it is many different diseases. The term includes a heterogeneous group of disorders that produce damage, defect, or disease to the brain of the young human being, in the uterus, at birth, or in the newborn period. Similarly, the signs and

symptoms range through a wide gamut of manifestations, such as spasticity, ataxia, athetosis, paralysis, etc. The spastic type comprises about sixty per cent of cerebral palsy cases, and is characterized by more or less sustained contraction of various groups of muscles, making it difficult for the patient to perform a dexterous act. The ataxic type, as the name implies, is predominantly manifested by incoordination and poor balance. Tremor also may be present. The athetotic type is characterized by more or less constant, bizarre, purposeless movements, often associated with facial grimacing, expiratory grunts, and incoherent expostulation.

Mental retardation is frequently coexistent with all types but not necessarily so, and it is possible for a child with cerebral palsy to have superior intelligence.

#### ***What causes cerebral palsy?***

There is an extremely wide range of causative agents, including difficult or prolonged labor, lack of oxygen for the fetus or for the baby in the immediate postpartum period, malformations or defects in development of the brain, infections in the mother during pregnancy, etc. Cerebral palsy, in its broadest sense, also would include diseases acquired in childhood, such as those due to meningitis, physical trauma, lead poisoning, progressive cerebral degenerations, etc.

#### ***What is muscular dystrophy?***

Muscular dystrophy is primarily a disease of the muscles, probably due to some enzyme or metabolic defect, and is characterized by symmetrical and progressive weakness and wasting of the limbs. This disease usually affects larger muscles first, then spreads to other skeletal muscles, and sometimes to the heart muscle. It can be inherited, and it occurs more often in males than in females.

# BRAINWASHING

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## ***What is brainwashing?***

The term "brainwashing" is an American journalist's translation of a Chinese phrase meaning "thought reform." It is a form of group political indoctrination employed primarily by the Communists in China to convert previously resistant or uncommitted people to Communism.

## ***Who invented brainwashing?***

Thought reform (a more accurate and preferable term) was introduced by Mao Tse-tung and his followers as part of their campaign to win over the Chinese people to the Communist cause. Mao, in his famous book on guerrilla warfare, points out that the people "are the water in which the guerrillas swim like fish." For the water to be just right for the fish, it was necessary that the people be persuaded to support, or at least not to oppose, the Communist revolution in China. It was for this purpose that thought reform was introduced.

## ***How is brainwashing accomplished?***

The candidates for thought reform are brought together in small groups (perhaps twelve men in a group) under the guidance of a trained and skillful Communist leader. Each group works and "struggles" together until all the members have seen the light. Each person reviews his entire life history in an attempt to see where his old ways of "wrong thinking" came from. As this goes on, the group leader constantly points out how the old ways of thinking were selfish, reactionary, superstitious, victimizing of others, prejudiced, etc. As the thinking becomes "reformed," it follows more and more closely a set pattern of attitudes whereby justice, equality, human rights, the brotherhood of man, democracy, racial tolerance, political liberty, etc., are found to



exist only within the framework of the Communist system. When the individual has accepted this, he is considered to have been reformed and will usually actively or passively support the Communist system (until or unless he becomes disillusioned). Such a convert to Communism by the Chinese group indoctrination technique is said to have been "brainwashed."

*Doesn't brainwashing involve drugs, conditioned reflexes, or some other application of science?*

There is no evidence that such techniques are involved in the process of thought reform in any way.

*But, aren't people frightened into being brainwashed?*

It is true that many of the Chinese who entered thought reform groups did so under pressure at first. However, because they were usually well treated, as part of Mao Tse-tung's policy of "leniency" even toward many of his former opponents, the suspicions of the prospective converts were usually quickly dispelled. Most of them threw themselves into the process vigorously and with enthusiasm, although, of course, there were many exceptions.

*Is hypnosis involved in brainwashing?*

It is true that under certain circumstances groups can be brought into a state of trancelike fascination by a strong leader who presents very positive suggestions in a repetitious or authoritarian fashion. It is possible that from time to time thought reform groups have entered into degrees of unified passion in which elements resembling hypnosis, or even religious ecstasy, might be present. However, formal hypnotism is not a prescribed feature of the process of thought reform.

*How, then, does brainwashing differ from propaganda?*

Propaganda implies a planned information program which is generally directed at a large and relatively uncontrolled audience. The thought reform technique relies heavily upon small group dynamics, the group structure, the relationship of the leader to the group, the relative initial psychological isolation of each individual from the other members of the group as individuals, and the evolution of a growing group identity and group pressure to bring the tardy or errant members into line.

***How does brainwashing differ from education?***

The process of education consists essentially in teaching people how to think for themselves in relationship to a variety of material with which the learning process equips them to deal. Thought reform is more accurately defined by the word "indoctrination" in which certain specific ideas and attitudes are inculcated deliberately and without the merits of competitive doctrines being offered.

***What is degrading about brainwashing?***

The impersonal forces that bring and hold the individual in the group, and the unstated menace that keeps him from deviating (in other words, the basically coercive nature of the process) must be considered degrading as any loss of freedom—whether voluntarily surrendered or forcibly removed—is degrading.

***Do people react in different ways to brainwashing techniques?***

There is every possible range of response. Some individuals have been able to resist it completely. However, it was remarkably successful in its effects upon the majority of those Chinese citizens to whom it was applied during the 1940's and 1950's.

***How long is brainwashing effective?***

This is a completely individual matter and no general estimate can be made. It now seems clear that some individuals successfully pretend to be converted and will defect from or covertly resist Communism even while appearing to have been well proselytized. Others apparently have experienced gradual disillusionment as the result of realistic experiences and of disappointments in the promises that are an inherent part of the program. Undoubtedly there are some who become fanatical and permanent converts, unshakable in their belief in the new way of thinking, and prepared to give up their lives for it.

***What might determine a person's degree of resistance to brainwashing?***

Each individual's susceptibility or resistance to the process will depend upon his understanding of what is being attempted, his background or knowledge of the subject matter, his familiarity with competing points of view, his capability for resisting group influences, his ability to form covert subgroups with others in opposition to the monolithic pressures upon them, and his innate spirit of independence and rebellion against coercive authority.

***Is being brainwashed a sign of weakness, poor heredity, or stupidity?***

There is no evidence for any such conclusions.

***Does brainwashing leave permanent scars?***

Any kind of effective indoctrination is bound to leave a lasting impression. However, there are certainly no physical scars, and there is no reason to think that any political attitude brought about by the process of thought reform might not be modified or even markedly altered as the result of subsequent learning on the part of the individual.

***Has brainwashing been attempted on people other than the Chinese?***

It has been attempted by the Chinese in their dealings with certain other people who have fallen under their control, particularly prisoners of war during and immediately after the Korean conflict.

***How effective was brainwashing against the American prisoners of war?***

This is a matter of considerable misunderstanding on the part of the American public. Unfortunately the impression was gained by many that members of the United States Armed Forces in Korea who became prisoners of war were easily "brainwashed" by the Communists, thereby being transformed into traitorous collaborators or political converts in large numbers. Official government figures reveal that this is far from true. Of the nearly 5,000 American prisoners of war who were returned to us after the cessation of hostilities, only a handful were subsequently tried by courts-martial for wrongdoing in the prisoner of war camps, and very few of these involved collaboration that could be attributed to the successful application of thought reform techniques to the American soldiers. Estimates made by some self-styled authorities that a large percentage of American prisoners of war became collaborators are incorrect.

***But, didn't some Americans go over to the Chinese side?***

There were 21 Americans who elected to go to China rather than to be repatriated after the war. They went as students and workers, not to wear the enemy uniform or to fight against their former comrades. Even of this small group, several have subsequently drifted back to the United States after becoming disillusioned with Communism or other

aspects of life in China. By contrast, there were thousands of Chinese who begged not to be returned to Red China.

*Weren't some American fliers brainwashed into making false confessions of germ warfare?*

In no way can the process employed by the Communists to extract false confessions of germ warfare from American fliers be compared to the technique of thought reform. Here is an example of how the word "brainwashing" is misleading. "Brainwashing" has, through loose usage, come to mean any way of getting anyone to do anything against his will, whereas we have already seen that the originally synonymous term, "thought reform," has quite a specific meaning.

"Confessions" have been forcibly elicited as part of the legal requirement for courtroom trial in Russia for many years, and in China since the Communist revolution. Most of the American fliers who eventually succumbed to the pressures upon them to sign confessions that they had engaged in germ warfare in Korea (which was untrue), did so after prolonged forcible interrogation that involved endless questioning, many threats, abuse, considerable physical discomfort, and (perhaps most important of all) prolonged chronic sleep deprivation to the point that some of the victims were no longer in full possession of their faculties. Furthermore, when not being interrogated, the individual flier was nearly always kept in solitary confinement; he was not placed in a thought reform group. No serious attempt at political indoctrination or conversion was made by the Chinese in most instances. Their purpose was to elicit false confessions for propaganda purposes; on their side they had time, a well-established technique, and highly experienced specialists on the interrogating teams; and they were about 60 per cent successful. (See *Sleep; Sensory Isolation*)

*Did brainwashing reveal the moral weakness of the modern generation of Americans as compared with more patriotic or heroic soldiers of yesteryear?*

Not only is there no evidence that such an allegation is true, but there is a great deal of evidence that it is completely false. In previous wars there have been many times that American prisoners of war behaved much worse than did the group of prisoners in Korea. In fact, the most completely American of all wars, the Civil War, was replete with examples of complete breakdown of morale and organization in prison camps, of which Andersonville was only one example. It is fair

to say that the American civilian-soldier who took the field in Korea was bigger, stronger, brighter, healthier, and potentially more effective as a fighting man than his counterpart in any previous war. Blame for shortcomings in training, preparation for combat, morale, or the national commitment to victory, cannot be laid at the individual soldier's door, nor at the door of his generation.

***Hasn't it been said that no American prisoner of war tried to escape from the camps?***

Actually, there were many successful escapes from temporary prisoner of war camps early in the Korean War. It was not until the summer of 1951 that many Americans were confined in permanent prisoner of war camps in North Korea and China. Armistice talks started soon afterward, decreasing the sense of necessity to escape. Even so, there were many attempts. That they were not successful may be understood in terms of the difficulty of the terrain, the skillful and deliberate disorganization of the prisoner groups by the Chinese (who removed all leaders and promoted fear and mistrust), and the great difficulty involved in an American creating a disguise suitable to get him through a countryside teeming with hostile Oriental people.

***Didn't other groups of prisoners of war, such as the Turks, resist brainwashing better than the Americans?***

This comparison has been made, but it is very misleading. The Chinese did not have Turkish-speaking interrogators, and were not carrying out a major propaganda campaign against the Turks, as they were against the Americans. Furthermore, the Turks were an elite, volunteer unit, physically much better trained for privation and combat, and welded together by long experience into a cohesive group; they were not riddled by rotations, hastily trained replacements, or the last-minute assignment of unfamiliar leaders.

***Didn't brainwashing break down the morale of the American prisoners to such an extent that many of them were weakened and died?***

There is no good evidence that this is true. Medical officers among the prisoners of war attributed most deaths to untreated wounds, malnutrition, infection, and exposure. There have always been instances of prisoners who became apathetic, depressed, failed to care for themselves, and died. However, there is no evidence that this was higher among Korean prisoners of war than among World War II prisoners

of war, and in some situations (e.g., Americans captured early in the war by the Japanese), apathy deaths were much more frequent during World War II than in Korea.

***Should we train our soldiers to resist brainwashing in case they become prisoners?***

Actually, the military services at the present time have survival courses for many of those combat personnel who are likely to be cut off in hostile territory. As part of these rigorous training programs, there is familiarization with the enemy methods and practice in techniques that previously have been successful in combating them (i.e., formation of covert resistance groups, concealment of leadership and chains of command, organization of escape maneuvers, muddying the waters as much as possible during the interrogation for intelligence purposes, etc.).

***Is such training inhumanly brutal? Is it likely to be successful?***

All successful training for conditions of extreme stress is of necessity uncomfortable, demanding, and, at times, even painful. Nevertheless, the degree of protection offered by such training has been proved again and again in military experience to be extremely worthwhile and to prevent even greater suffering or death when the actual combat situation is experienced. Virtually all of the American military personnel who have undergone such survival training courses have declared themselves grateful for the opportunity to learn more about what they might possibly have to face, and have felt themselves to be more confident in their ability to survive with honor if they should become prisoners of war.

***Is brainwashing a serious threat to our nation today?***

It is certainly a threat in the sense that it has proved to be effective when employed as a means of persuading a large group of underprivileged and tyrannized people to change their political attitudes and allegiances in such a way as to support the Communist cause. Small group political indoctrination of people with real grievances has always been successful in creating support for revolutionary movements. In many ways we have failed to export the American revolution; in Asia, with the help of thought reform, the Communists are promoting theirs.

Perhaps the most insidious domestic threat posed by the shibboleth

of "brainwashing" is the tendency of Americans to believe in its power and in our own weakness. Misinformation and the distortion of facts have led to self-criticisms that sound remarkably like the Communist line about us: that our brainwashable young men are corrupt and suffering from defective character, that our institutions (family, church, school, and society) have failed to produce individuals of firm patriotic convictions or strong moral fiber, and the like. Despite the fact that there is no good evidence that Americans are particularly susceptible to the pressures of Chinese thought reform, these arguments have been used to support a variety of panicky enterprises, ranging from irresponsible "anticommunist schools" to weekend vigilante groups of self-appointed "minutemen." Of incidental interest to the reader may be the fact that some of these extremists equate psychiatry and the entire mental health movement with the "brainwashing threat" which, together with other insidious influences (such as the fluoridation of water), they fear is threatening America from within.

*How can we protect ourselves against these threats?*

In the underdeveloped areas and with the masses of uncommitted people in Africa and Asia, counterindoctrination methods, propaganda, information centers, truth campaigns, free radio programs, etc., may all be of some usefulness. However, the most effective means of opposing Communist use of thought reform to subvert whole groups of people and nations, is to oppose and hopefully to correct the conditions (ignorance, racial prejudice, poverty, disease, injustice, lack of opportunity, lack of human rights, gross class inequalities, and tyrannical or dictatorial political subjugation) that make people most vulnerable.

At home we should be less ready to accept the opinions of those who would frighten us by attacking our self-confidence or our faith in the national character. It is always tempting to view with grave concern the decay of the younger generation, and to yearn for the bygone virtues of the pioneers and patriotic warriors of the nation's glorious past. But the facts, as they continue to emerge (albeit not as colorfully nor as loudly as the alarming distortions), are heartening about the present and indeed about the future. The captured American soldiers in Korea showed remarkable resistance to "brainwashing" by the Chinese. The nation as a whole would do well to follow their example in resisting the emotional uproar created by those who would shake our confidence in the continuing, and growing, high quality of the American national character.

# CAREERS IN MENTAL HEALTH

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***Which professions work primarily in the field of mental illness and mental health?***

There are several major professional groups in the mental health field. *Psychiatrists* are medical doctors who have continued their professional preparation for several years after graduating from medical school in order to become specialists in the treatment of mental illness. *Psychologists* are usually doctors of philosophy (in psychology) who have received their postcollege education in university graduate schools, specializing in research approaches to the understanding of human behavior. *Social workers* are those who after college have continued their academic study in professional schools of social work, where they learn theory, methods, and techniques for helping people in trouble. *Psychiatric nurses* are nursing school graduates who specialize in the techniques of dealing with patients in mental hospitals. *Occupational therapists* are persons who have completed a special five-year collegiate program concerned with methods and techniques of helping patients, including mental patients, experience the therapeutic values of carefully planned activities.

Another professional group should be mentioned at the outset. *Psychoanalysts* are a very highly specialized group, numerically small, but important in terms of their contributions in theory and technique to all of the mental health professions. Psychoanalysts use a specialized approach to the understanding and treatment of emotional disorders, based on the theory of human personality development that originated with Sigmund Freud. In the United States, most psychoanalysts are psychiatrists who have continued their training by specialized study of the methods and techniques used in this particular theoretical approach. There is a small but increasing number of professional people in the other mental health professions who use psychoanalytic theory and methods in therapy.



***Are there other people who work with the mentally ill and emotionally disturbed?***

Members of many professions work with a variety of chronically disabled people including the mentally ill. Occupational therapists are a good example. They work with all varieties of medical conditions, where their special knowledge of the therapeutic benefits of specially planned activities is used in treatment. Their skills are useful with mental patients too. Another professional group, to which emotionally disturbed people often turn first, is the *clergy*. Increasingly the training of clergymen includes specialized knowledge in the fields of counseling and abnormal psychology. There is still another group, the *special teachers*, who are trained to deal with the problems of both the emotionally disturbed child and the mentally handicapped child. These teachers may work in the regular school system or in residential homes for disturbed children.

A large number of scientific disciplines make important contributions to our understanding and treatment of mental illness. Although members of these groups may have less personal contact with patients, their research findings are often helpful in unraveling the mysteries of mental illness.

*Biochemists* have helped in the understanding of some of the puzzling physical accompaniments of mental illness and have developed drugs useful in their treatment. Contributions continue to be made by *geneticists*, *epidemiologists*, and *neurologists*. Almost any field of scientific research into human and animal structure and function may be expected ultimately to help untangle some of the intricate mysteries of mental illness.

Because large numbers of the mentally ill are treated in hospitals and clinics, members of many other occupational groups are required for the staff. *Medical librarians*, *medical secretaries*, *vocational counselors*, and *laboratory technicians* are just a few examples of these. *Rehabilitation counselors* play an important role in helping the recovered mental patient find his way back to normal community activities and employment.

***What are some of the reasons for the shortages of professional mental health personnel?***

First, the shortage of professional people in mental health is part of a general shortage (in our society) of people with lengthy specialized

education. All of the mental health professions require extensive educational preparation. There are many pressures on young people graduating from high school, or graduating from college, to seek immediate employment rather than continue their education. The increase in early marriages, the availability of jobs, the money and time needed for further education, all tend to discourage extended professional training.

Education requires the sacrifice of certain immediate satisfactions for the attainment of future goals. Many of the reasons for our shortages of mathematicians, chemists, engineers, and microbiologists, to mention just a few groups, also account for the shortage of professional mental health workers.

There are other reasons too. Few young people in high school know much about career opportunities in the mental health professions. Most present-day psychiatrists, psychologists, social workers, psychiatric nurses, and occupational therapists are people who have entered these fields after first deciding on other careers.

Although many girls in elementary school or high school already know that they want to be nurses, few of them have ever heard about the particular specialty of psychiatric nursing. Many career decisions are made in high school, yet very few high school students have had a chance to learn about occupations such as social work; and few high school students can accurately describe the difference between a psychologist and a psychiatrist. Information about all these fields usually comes late, during college, when career decisions may already have been made.

There is a further reason for a shortage of mental health workers. Mental illness remains a strange and mysterious condition to many people. There is a long historical tradition that ascribes emotional illness to sin, possession by devils, witchcraft, and other fearful causes. Only during the present century has mental illness been recognized as understandable in terms of biological and social causes. Some of the mysteries and terrors of the older explanations linger on. Parents are often reluctant to see their children choose a career in one of the mental health fields. Gradually these attitudes are changing but they still influence choice of career.

Finally, certain social conditions account for the shortage of mental health workers. The population of our country is growing by about three million persons a year. This means that there is a large increase in the number of babies and young children, and at the same time there

is a large increase in the number of elderly persons in our population. Both of these groups, the young and the old, require more than the usual amount of psychological help.

As our population increases, it also becomes more urbanized. People are crowded into cities. Each census finds fewer people living on the farms and more people in urban areas. When people are crowded together, the amount of mental illness, or our lack of tolerance of it, increases the need for psychological help. The mental health professions are urbanized because the demand for service is greater in urban areas; but these professions are not growing as fast as either the population or urbanization.

*Is the shortage likely to continue?*

Several years ago, Congress appropriated funds to the National Institute of Mental Health to support a Joint Commission on Mental Illness and Health, organized to make a study of our national needs and resources in mental health and to make recommendations for the improvement of the care and treatment of our mentally ill.

After a careful study, the Joint Commission outlined a series of urgent recommendations to Congress and to the states. In instance after instance the recommendations for the care, treatment, and rehabilitation of the mentally ill, and for research into causes and prevention of mental illness, called for a very large increase—over the normal rate of increase—in the number of trained professional personnel. There is no question that a serious shortage of specialists in the mental health professions and related occupations will continue for the foreseeable future.

One recommendation of the Joint Commission on Mental Illness and Health was concerned with the need for psychiatric treatment wards in general hospitals. The report urged that no community general hospital of more than one hundred beds be considered adequate without a psychiatric treatment unit for the people served by the hospital. The fact is that at present there are only about six hundred general hospitals in the entire United States with facilities for the care of mental patients beyond emergency admission. This means that there are about four thousand general hospitals in the country without such psychiatric units. A psychiatric unit in a general hospital requires at least the half-time services of a psychiatrist, a psychologist, a social worker, psychiatric nurses, aides, and technicians. We immediately see a potential demand

for thousands of trained professionals to realize this newly established goal.

Another recommendation was concerned with community mental health clinics. It has been demonstrated many times that emotionally disturbed people can be helped in a community clinic. The Joint Commission recommended a well-staffed, full-time mental health clinic for each fifty thousand of population. Although this does not seem like an excessively high goal, the number of trained professionals required to provide this amount of service is staggering. To bring all the states up to this goal would require nearly half the membership of the present professional associations of psychiatrists, psychologists, and social workers. Obviously, such clinics are not going to be established overnight, but efforts toward the realization of this goal will continue to make demands on professional manpower.

A third recommendation was concerned with the establishment or expansion of psychiatric clinics for children. Here, too, there is a bleak shortage of qualified people. We are training fewer than fifty child psychiatrists a year in the whole country. We could use many times this number. The same sort of desperate shortages of manpower exist in child psychology, school social work, pediatric nursing (nursing in children's treatment centers), and other specialties in education and rehabilitation.

Any young person who aspires to a career in one of these mental health professions may be reasonably certain that challenging employment opportunities will be available throughout his professional life. There is no unemployment in any of these fields now, and every indication is that there will be full employment in the future.

### *Where do members of the mental health professions work?*

Most people in the mental health professions work in urban centers and many are employed by clinics and hospitals. There are variations that will be dealt with under the professions separately. For example, most psychiatric nurses and most occupational therapists are employed in mental hospitals. A very high proportion of psychiatrists are in private practice seeing patients in their own offices, although many of them also work part time at hospitals or clinics. Psychologists and social workers are likely to work in hospitals and clinics more often than in private practice, although there is an increase in private practice for members of both groups. Psychologists teach in colleges

and universities and work in research laboratories in greater numbers than any of the other professions. Social workers work in a greater variety of settings than any other group.

Many members of each of these professional groups work at activities not directly connected with the care and treatment of mental patients. Because of the demand for more people in all the mental health fields, many members of these professions are engaged in teaching activities. There has been a sharp rise in the number of professional education programs in most of these fields since World War II.

### *What does the psychiatrist do?*

The educational preparation of the psychiatrist is long and difficult. By the time the psychiatrist has completed his training he has learned both the organic and psychological determinants of mental illnesses, and how to treat mental patients both by physical and psychological means.

Within psychiatry there are quite different, but often complementary, approaches to the problems of mental disorder. One approach seeks to find causes of disturbed behavior in biochemical and physiological systems and in the malfunctioning of the nervous system, particularly the brain. Psychiatrists who emphasize these areas usually treat patients with drugs and other physical therapies.

When no organic causes can be found, or when organic factors are minimal, emphasis may be placed on psychological determinants. In many patients, emotional difficulties seem to arise out of interpersonal conflicts, faulty childhood experiences, and difficulties in relating to other people. Psychiatrists most interested in this approach, who are usually referred to as "dynamically oriented," attempt through personal office interviews to assist the patient in gaining insight to the roots of his emotional difficulty and in learning more effective ways of dealing with his conflicts and problems.

Psychiatrists can also be classified according to the groups they serve. The child psychiatrist, for example, specializes in the emotional problems and difficulties of children and often works in private practice or in a child guidance clinic. The industrial psychiatrist attempts to work with the problems and difficulties of people in industry; the military psychiatrist studies and treats emotional problems associated with military service. Other groups within psychiatry are employed in public health and emphasize approaches to prevention, and in psy-

chiatric research laboratories concerned with the discovery of the causes and treatment of mental disorders. The majority of psychiatrists, however, tend to concentrate on adult disorders.

Most psychiatrists will be found in their own offices engaged in the private practice of their specialty. The average psychiatrist draws on all the knowledge and techniques that have been developed in his field. He may see many kinds of patients ranging from the mildly disturbed to the severely psychotic; he may treat both children and adults or persons with brain injuries, neurological disorders, and emotional problems. Although a majority of psychiatrists are in private medical practice, manpower studies have found that significant numbers of them spend part of their time in teaching, in community service, and in consultation with clinics and hospitals.

Closely related to psychiatry is the field of neurology. Psychiatrists who seek to qualify for certification by the American Board of Examiners in Psychiatry must also pass an examination in neurology. There is a separate group of medical specialists who are called neurologists, who in turn are expected to have a knowledge of psychiatry. Actually these fields overlap to the extent that the nervous system and brain are involved in many disorders within the specialty areas of each field.

Whether the psychiatrist is inclined toward the organic or toward the dynamic approach to mental disorder, he is the only member of the mental health team licensed by society to prescribe drugs and surgery used in the treatment of mental patients. Usually the psychiatrist is the director of the clinic or professional service in the hospital, and bears legal responsibility for the patients in his charge.

The work of the psychiatrist is infinitely varied and fascinating. It is also very demanding on both his time and emotional stability. Aspiring psychiatrists should be well-adjusted people who not only will be able to succeed in completing the long training required but will also be able to sustain demands made on them by one of the most difficult kind of case loads of any medical specialty.

### ***How does one become a psychiatrist?***

All psychiatrists are physicians. Therefore, any person planning a career in psychiatry must make early preparations in order to qualify for admission to medical school. The high school and college counselor can provide detailed information on courses required for admission

to medical schools. The student should realize that medical school admission is difficult because of the large number of applicants, and that medical education is expensive and lengthy. In high school and college the student must complete a number of science courses including biology, chemistry, physics, and mathematics.

Many medical schools are liberalizing entrance requirements to the extent that applicants may elect college majors in the behavioral and social sciences and humanities rather than in the traditional physical sciences. But the basic science courses remain a prerequisite for admission. A few medical schools are accepting students after three years of college.

When the student aspiring to a career as a psychiatrist has completed four years of medical school he is still a long way from his goal. He must complete at least one year of internship and then begin a residency training program, in a mental hospital, that can range from three to seven years, depending on his field of special interest in psychiatry.

### *What does the psychologist do?*

Psychology may be defined as the scientific study of human and animal behavior. Psychology is a very large field, but all psychologists do not work directly, or even indirectly, with mental patients. Large numbers of psychologists teach in colleges or work in research laboratories. Many others work in counseling centers. Many are employed by industry in personnel work, selection, and training.

The psychologist most immediately concerned with the field of mental illness is the clinical psychologist. The clinical psychologist is employed as part of the mental health team in clinics and mental hospitals throughout the country. One of his important functions is diagnostic testing, in which he uses a variety of measures of intelligence, personality, aptitudes, and interests to determine what factors are responsible for the patient's emotional problems. The clinical psychologist participates in individual and group therapy with mental patients. In recent years he has assumed an active role in mental hospital ward management, and in group activities with patients, such as patient government.

Because his educational experience emphasizes research training, the clinical psychologist often engages in a significant amount of research, seeking to uncover causes of mental illness and methods effective in restoring mental health.

Most clinical psychologists have earned a doctor of philosophy degree. However, the great demand for psychological services since World War II has exceeded the supply of people available with the result that some psychologists have accepted jobs after receiving their master's degrees.

In recent years there has been an increasing tendency for clinical psychologists to engage in private practice, mainly on a part-time basis. It seems likely that this tendency will continue, and that there will be opportunities for psychologists to provide testing, counseling, and therapeutic services to the public for fees, in addition to the regular career opportunities in agencies and institutions. Because certain activities of the clinical psychologist overlap those of the psychiatrist, these two disciplines have been seeking to work out ways to prevent any serious disagreement. Psychiatry feels that clinical psychologists should do psychotherapy only under medical supervision. Psychologists feel that while they should collaborate with physicians to ensure their clients' physical health, as would a dentist, they cannot accept a subordinate role. The student contemplating a career in clinical psychology should get thorough guidance on the complexities of this problem.

Significant numbers of psychologists are employed in basic research, where their contribution to the solutions of problems in mental illness would be comparable to contributions of scientists in other biological fields. Many psychologists are engaged in relatively pure research, but as findings in any branch of science may ultimately find application to the solutions of practical problems, so the work of these psychologists can be considered to be pertinent to the mental health field.

The field of psychology has expanded enormously in the past fifteen years. Psychologists may now be found in leadership positions in a wide variety of public mental health agencies, in teaching positions in professional schools, and in various governmental agencies. Teaching and administrative careers are a major possibility in the field.

### *How does one become a psychologist?*

Professional work in the field of psychology requires graduate training beyond the college level. Most professional psychologists have completed a college major in psychology, or in some related field such as biology or sociology, and have then continued their education in a graduate department of psychology in a university.

Most large universities have a graduate department of psychology, where the prospective psychologist may work toward the master's de-



gree (M.A. or M.S.) and the doctor of philosophy degree in psychology (Ph.D.). The time required for the completion of a master's degree is approximately two years following graduation from college. The time required for completion of a Ph.D. degree is approximately four years after graduation from college.

In addition to taking courses in the various areas of psychology, the graduate student working for advanced degrees is required to spend a large part of his time on research projects and, in the case of clinical psychology students, in fieldwork placements in clinics and hospitals.

The Ph.D. candidate must also pass reading examinations in two foreign languages, usually French and German, although some universities now permit an examination in statistics in place of one language.

Since the end of World War II, enrollment in graduate schools in psychology in the United States has shown a phenomenal increase. Psychology has moved from a prewar position of twentieth place to a present position of second place in terms of the total number of graduate students enrolled in Ph.D. programs. Only chemistry has more Ph.D. students. As career opportunities in psychology have become better known and as demand has increased, large numbers of college students have decided to enter psychology as a career.

Most graduate schools require that a student have an excellent undergraduate record in order to be admitted. Graduate departments of psychology often urge undergraduates to take courses in biology, physiology, statistics, and the basic sciences in general, along with work in the social sciences.

### *What does the social worker do?*

The social worker is a member of a professional discipline that has developed very recently. The social worker uses methods and techniques that have been found to be effective in helping people help themselves. The casework method uses the face-to-face interview and the personal relationships it involves, to help individuals in trouble. The group work method uses knowledge of group characteristics to bring help to people in groups.

The various specialty areas of social work are in part determined by educational specialization and in part by the places where social workers are employed. Medical social workers, for example, are found primarily in hospitals, where they provide help and support to patients and their families in adjusting to all the difficulties that illness and hospitalization can bring about. School social workers are employed in schools,

where their job is to help pupils and their families with whatever difficulties may be interfering with the effective educational achievement of the pupil. Psychiatric social workers are employed by mental health clinics and mental hospitals. The psychiatric social worker is the professional social worker most closely related to the mental health field, although nearly all social workers are concerned in some measure with helping people deal with crises and accompanying emotional problems.

The psychiatric social worker is a member of the team of professionals whose skills are pooled in helping individual patients regain their mental health. The psychiatric social worker in the mental hospital often does the initial interview with the patient and with the patient's family, interpreting to them the functions of the mental health center and clarifying their concepts of what treatment involves and what they may expect from treatment. He may discuss the development of the patient's illness with relatives, friends, and employer. Very often the psychiatric social worker engages in continuing interviews with the patient himself, using the casework method in an attempt to nourish and support whatever positive components exist in the patient's personality. He may help recovered patients in the problems of returning to home and community.

In addition to clinics and hospitals, psychiatric social workers may also be found in juvenile courts, community and state health departments, and, occasionally, in private practice.

The social group worker is hired by groups that are formed to help members achieve better personal and social development. Social group workers are employed in community centers, settlement houses, mental hospitals, and children's hospital wards, and by organizations such as Boy Scouts, Girl Scouts, and the Y.M.C.A.

The community organization worker works with those agencies and people within the community that can help bring about improvement in institutional structures in an effort to alleviate personal crises and intergroup tensions.

There are many other kinds of social workers, but the mentioned specialties will give an idea of the diversity of the field.

Generally the training of social workers is so broad that they are prepared to move from one specialty area to another depending upon social need. Social workers have a well-worked-out system of supervision that provides a source of constant support and growth for the student and the newly trained worker.

***How does one become a social worker?***

Because of the relatively recent development of this professional field there are many persons employed in social work and social welfare positions who are not fully trained social workers, although nearly all of them have college degrees. Leaders in the social work profession feel that after college at least two years in a professional school of social work is necessary before the person may be fully qualified. In recent years there has been a trend toward even more education, and some social workers preparing for teaching or administrative careers earn doctors' degrees in social work.

While in college, people who are planning a career in social work usually major in one of the social sciences such as sociology, psychology, economics, anthropology, and history. Many colleges and universities have developed a major in social welfare, which combines offerings from various social studies into a unified program. However, because so many students decide on a career in social work relatively late in their college planning, professional schools of social work are more likely to be concerned with the student's maturity, motivation, and his interest in a lifelong career in helping people, than in specific college courses.

During the student's professional education in a school of social work he learns basic theoretical approaches to the growth and development of human personality. He studies the organizational structure of society as it affects the individual, family, group, and community. He also learns techniques and methods found to be effective in helping individuals and groups maximize their resources to solve their problems. The professional preparation of social workers includes both extensive supervised experience in actual settings where social workers are employed and an acquisition of basic skills in research techniques.

Until World War II, social work was largely a woman's profession. Since World War II, large numbers of men have entered this field because of the exceedingly attractive career opportunities. At the present time nearly half of the total number of students in schools of social work are men.

***What does the professional psychiatric nurse do?***

Nearly every schoolchild has a clear image of the nurse, characteristically involving a young woman whose bedside duties ease the pain and discomfort of physical illness. Relatively few young people are

aware of the career opportunities in psychiatric nursing, which involve many different nursing skills and duties. Nor are many aware that psychiatric nursing in particular, and nursing in general, offer careers to men as well as women. In some mental hospitals at least 25 per cent of the psychiatric nurses are men.

The duties of the psychiatric nurse are determined in part by the need for mental hospital personnel. The field of psychiatric nursing is desperately short of trained people. Any young person whose interests include both nursing and work with the mentally handicapped or mentally ill may be certain of employment opportunities for the foreseeable future. One result of the shortage of psychiatric nurses has been an attempt to fill positions in mental hospitals with psychiatric aides and practical nurses. This means that often the few trained professional psychiatric nurses working in these hospitals are largely occupied with the supervision and training of these other people.

The duties of the psychiatric nurse have been developing and changing with changes in the treatment of mental patients. Only in recent years have all student nurses been required to spend a part of their training period in a mental hospital. This experience is not intended to make psychiatric nurses of the students. However, leaders in the field of nursing believe that the psychiatric experience broadens the perspectives of the future nurses and makes them more sensitive to the emotional components of all illness.

The psychiatric nurse works with mental patients. Inasmuch as mental patients are usually not physically sick in the same way as patients in a general hospital, the duties of the psychiatric nurse are quite different and varied from bedside nursing. There is little bedside nursing in the mental hospital except for the wards for the aged, the infirmaries, and the neurological wards. The nurse, instead, uses knowledge of emotional disorder in a therapeutic way by interacting with the patient, by keeping careful notes of his observed behavior, and by providing a model of sane orderly behavior, which patients often find reassuring and which they attempt to imitate. The psychiatric nurse also participates in administering treatments such as electroshock, drug medication, and similar procedures requiring nursing assistance.

Psychiatric nursing is difficult and demanding. It requires patience and stability. One of the satisfactions of regular hospital nursing is seeing patients get better and go home. In the mental hospital, the psychiatric nurse works with a more chronic group of patients. The mental hospital may lack the best and most modern equipment; indeed

the nurse may find some of the essential nursing equipment not available. Patient loads are heavy. Despite all of these disadvantages, many nurses choose psychiatric nursing as a fascinating and challenging area in which to work.

*How does one become a psychiatric nurse?*

Many leaders in the nursing profession would define a psychiatric nurse as one with a master's degree in nursing, who has received special training in the care and treatment of mental patients. Defined in this way, there are relatively few psychiatric nurses in the country. On the other hand, most manpower studies count as psychiatric nurses those nurses employed in mental hospitals where they may be receiving on-the-job training and supervision from a more highly skilled professional nurse, from a psychiatrist, or from other specialists.

The prospective psychiatric nurse, or the prospective nurse in general, should become acquainted with the three basic roads leading to professional work in nursing. The largest group of nurses comes from the traditional hospital school of nursing. This usually involves a three-year program in a general hospital following graduation from high school. Upon completion of these three years the student receives a diploma and, after taking a qualifying examination, is registered by the state. During the three years the student nurse has a field placement, usually for three months, in a mental hospital.

A new nursing program has been developed which involves a course of academic study and fieldwork usually lasting two years in a community college or junior college. During this time the student studies the theory and practice of nursing along with basic science and art, and receives an Associate in Arts degree along with her nursing diploma at the end of the training period. During this program the student nurse receives a certain amount of supervised experience in hospitals, including a mental hospital, but she does not live in the hospital as is the case with the first type of program. Many nursing leaders view this as the nursing education pattern of the future.

A third type of program requires training in a college or university, usually in close cooperation with the university hospital and health services. If the program leads to a bachelor's degree, this type of training requires four or five years. Some universities require, or permit, various combinations of college work and hospital training leading to the academic degree. Some, for example, require two years of college work for admission to the nursing program. There are also universities

with master's degree programs during which the student may specialize in a particular field of nursing such as psychiatric and public health nursing. Often the master's programs lead to teaching and supervisory positions. The pupil interested in combining college work with a nursing career should obtain careful counseling on the various patterns possible. Often financial help is available.

With so many different kinds of nursing education open to the prospective nurse he or she ought to obtain full information on the alternative programs while in high school, if possible, in order to make a decision on the program best suited to his or her long-range goals and in order to know what high school subjects will be most helpful. In any program the prospective nurse will need to take courses in biology, chemistry, and the social sciences in preparation for future specialization.

#### *What about practical nursing opportunities?*

For persons who have not completed high school or for those persons who feel they are too old to enter one of the lengthy training programs in professional nursing, there are career opportunities in practical nursing that prepare the individual for work in a psychiatric hospital. Practical nurses engage in a variety of nursing services, usually under the supervision of a professional nurse or doctor. This is a new career opportunity that is growing and changing rapidly. It is a definite possibility for many women who want to work with patients but to whom the long educational requirements in professional nursing are impossible.

There are two principal types of practical-nursing schools. The first is part of a public school, such as a vocational school or adult education program. The other type is a private school run by a hospital, or junior college, or university. Expenses are not high to the student and in some cases the course is free. A course in practical nursing usually takes about one year. Mental hospitals are among the major employers of practical nurses and sometimes offer courses in practical nursing.

#### *What does an occupational therapist do?*

Occupational therapy is one example of a number of fields of specialization in which specialists work with a wide variety of illnesses, including mental illness. The skills and methods of the occupational therapist are useful in many chronic conditions, and research is now demonstrating their value in more acute conditions as well.

The occupational therapist in the mental hospital plans and supervises a variety of activities that have therapeutic value in helping the mental patient toward recovery. Work may be repetitive and calming, or it may be creative and stimulating, depending on the needs of the patient as determined by consultations between the occupational therapist and the psychiatrist.

This new profession is growing and changing. The interested student should get descriptive material to learn its variety and challenge.

***How does one become an occupational therapist?***

High school graduates enter a special college program that leads to the bachelor of science degree in occupational therapy after five years. Students already in college, or college graduates, may take part in special intensive training lasting eight months to a year in order to be qualified.

***Where can one find more detailed information about careers in mental health?***

One of the best sources of information about educational requirements in any specific mental health career is the school, college, or university in which such educational programs are located. A postcard to the educational center, requesting information and program catalogues, is sufficient. If information is requested from several schools, a pattern of requirements and curricula begins to emerge.

If the aspiring student lives in a metropolitan area, he will find the names of various local professional associations in the telephone book. A call is usually enough to bring a large supply of career information. Sometimes it is possible to visit a university department, a hospital, or one of the variety of training centers. Often a teacher or guidance counselor can help plan such visits. Sometimes arrangements can be made for a group to go together. Many schools have Career Days, on which experts from a large number of occupations are brought together to discuss their specialties.

The reference room of the nearest public library is likely to have career publications on file.

Students, parents, and counselors may be interested in a book, *Mental Health Manpower Trends*, by George W. Albee, which describes the history, present status, and probable future developments of the mental health professions and contains detailed tables on numerical trends in

all fields, shortages, and projection of future degree trends. The final report of the Joint Commission on Mental Illness and Health, titled *Action for Mental Health*, is an excellent summary of the history, present status, and future of the whole field.

Many national organizations provide all sorts of career information. Public librarians can supply lists that would include the following:

Health Education Division  
American Medical Association  
535 North Dearborn Street  
Chicago 10, Illinois

National Association for Mental Health, Inc.  
Division of Education Services  
10 Columbus Circle  
New York 19, New York

National Institute of Mental Health  
Career Information Service  
Bethesda 14, Maryland

Students who are interested in one of the particular mental health fields may obtain information on careers by writing to the national headquarters of the professional association to which most members of the profession belong. The addresses of some of the professional associations follow:

Public Information Service  
American Psychiatric Association  
1700 Eighteenth Street, N.W.  
Washington 9, D.C.

Committee on Careers  
National League for Nursing  
10 Columbus Circle  
New York 19, New York

American Occupational Therapy Association  
250 West 57th Street  
New York 19, New York

National Association of Social Workers  
95 Madison Avenue  
New York 16, New York



**National Federation of Settlements, Inc.**  
**226 West 47th Street**  
**New York 36, New York**

**Council on Social Work Education**  
**345 East 46th Street**  
**New York 17, New York**

**The American Psychological Association**  
**1333 Sixteenth Street, N.W.**  
**Washington 6, D.C.**

# CHARACTER STRUCTURE

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## ***What is character?***

Character is the tendency of an individual's behavior to be consistent with a set of values to which he is committed. It includes both the persisting habits of the individual and his tendency to make choices in line with his values. It includes the capacity to work diligently toward long-range goals and to avoid being diverted either by obstacles or by the attraction of more immediate goals of lesser worth. (See *Morals, Values, and Mental Health*)

## ***What is the difference between character and personality?***

Character is a part of personality. Personality includes all the behavior patterns of the individual, not merely those that are associated with socially derived values. Personality also includes the perceptual, cognitive, emotional, and motivational processes of the individual. Character has to do with behavior per se, although this is usually studied within the context of other personality processes. (See *Personality*)

## ***Is there a difference between character and character structure?***

No. Character itself is thought of as the structure underlying behavior or conduct.

## ***What is structure?***

Structure is a concept applied to a grouping of (inferred) personality factors underlying the occurrence of observable regularities in behavior. Thus, character is like atomic structure: both are constructs invented by scientists to help in understanding and ordering great numbers of observations.

## ***Is "good character" the same as good character structure?***

"Good character" has to do with the social reputation of an individual. It is determined by how other people judge a person in rela-

tion to the values of their own group. Character structure, on the other hand, can be evaluated by the psychologist independently of the specific content of the individual's values. In general, people who are reputed to have bad character are also seen by the psychologist as having weak (bad) character structure. However, people with reputations for good character may or may not have good character structure; their character structure may be too rigid or restricting to be considered healthy (good).

***Why are the terms "weak" and "healthy" used rather than "bad" and "good"?***

Because the psychologist attempts to study personality without making the moral judgments that are customary in American culture.

***Does this mean that the psychologist makes judgments that are not based upon values?***

No. The psychologist must call upon values in making and ordering his observations. However, his value system is somewhat different from the value system of American culture.

One difference is that American culture emphasizes specific ways in which a person should act, whereas psychology is equally concerned with emotions and motives that underlie actions. For example, a woman is admired by her neighbors for being a meticulous housekeeper, a dependable P.T.A. member, and a conscientious den mother. These are considered signs of "good character." A psychologist notes that she is mildly depressed most of the time and learns that she never has moments of great joy. From his point of view, her character structure is too restricting. (See *Culture and Personality*)

***Are character and happiness somewhat opposed to each other?***

Only if you equate happiness with satisfaction of short-term goals. Dedication to fun seeking may stifle the development of character. But if happiness is understood to include a zest for life or a general glow of well-being, then its attainment is dependent upon the development of sound character structure, which has to do with the stability of one's habits and one's decision making.

***Is the more stable character structure more sound?***

No. Sometimes habits become too rigid. For example, a successful but ulcerous businessman was advised by his doctor to relax and

take time off for recreation. He arranged his schedule to include three hours and fifteen minutes on Friday evenings for taking his wife to the movies. He was henceforth conscientious in keeping this appointment regularly. Although he changed his weekly schedule slightly, his character structure remained rigidly unchanged.

***Is it better to have a somewhat unstable character structure?***

Unstable implies change without orderliness. A flexible character structure is one that changes in an orderly manner to adapt to changes in the life situation of the individual.

***Do people today have less character than people had fifty years ago?***

Yes, that is probably true. A notable proportion of people today lack the rudder provided by a firm commitment to values. Therefore they drift through life without a sure sense of direction. They are more vulnerable to feelings of futility, of emptiness, and of meaninglessness. Like the *Stranger* of Albert Camus, they reach the peak of their own potential experience with the attainment of indifference.

***Why has this general weakening of character occurred?***

We do not know for sure, but partly this seems to have been a by-product of the attack on neurosis. When it was discovered that neurotic symptoms result from the repression of feelings and impulses, a concerted effort was made to help people lift these repressions. Much change has occurred in this direction so that Americans are much more aware of their own motivations than they were a few generations ago.

***Doesn't the lessening of repressions represent an improvement of mental health?***

It does, so far as it goes. Neurotic symptoms diminish with the lifting of repressions. The lifting of repression also leads to the dissolution of irrational values. However, if irrational values are not replaced by rational values, then character problems begin to take the place of neurotic problems. Perhaps the most pressing personal pursuit of our times is the quest for identity. The sense of identity is intimately involved with commitment to values, so that this search for identity is essentially a character problem. (See *Identity*)

***When are character structure and the sense of identity usually formed?***

They begin to form in early childhood. The parents' "yes" or "no," smile or frown, pat or slap carry the message of "good" or "bad"

to the child. The child's reaction to this message determines whether values will be learned. A mistrustful child may either defy or simulate compliance. However, if the child trusts his parents, he will probably introject the value.

***What is introjection?***

It is the process by which an individual takes a value "inside" himself. Through reward and punishment, a child learns first to comply with a value in the presence of his parents. Later, when his behavior away from the presence of his parents conforms with the value, he is said to have introjected the value. (See *Mental Mechanisms*)

***Is the sense of identity also determined by introjection?***

Partly, but it is also determined by identification.

***What is identification?***

It is the process through which an individual models himself after another person. In a healthy family the child tends to admire the parent of the same sex and strives to become like him.

***Is the formation of character always a conscious process?***

No. Many values are learned in early childhood through conditioning. If the parents respond in a consistent, positive manner to a particular behavior of the child, he may behave more frequently in this way. He may come to feel implicitly that this is a "right" way to behave because it "feels good" when he behaves this way. This can be described as the learning of a value, which is then thought of as part of the person's character structure. Neither the parents nor the child need have been conscious of the learning that took place. The same kind of unconscious learning can take place with negative values.

***Does a person inherit any part of his character structure?***

Not directly, but inherited constitutional factors do influence the formation of character. Some of these factors are body type, energy endowment, motility, and emotional endowment. (See *Constitutional Variation and Mental Health*)

***How do social factors affect character structure?***

Social factors are fundamental in the development of character structure. At first, the culture influences the child exclusively through

the parents, but as the child moves out of the family into increasing contact with neighborhood, school, and church groups, his character is directly influenced by a variety of social factors. Class values, ethnic values, and later on the values of a business organization or of his profession—all these and many more may affect character changes. (See *Social Factors in Mental Illness; Social Status and Mental Health*)

***Is character formed entirely in childhood?***

The major patterns of character seem to be formed in the first years of life. However, values are learned and changed throughout adolescence, young adulthood, and even in maturity.

***Do psychologists agree on one way of classifying character structure?***

No. Psychology is a relatively new science, and disagreement among scientists is a healthy condition in a new science. As on many issues, psychologists differ in the ways they classify character structure.

***What is the most widely used system for classifying character structure?***

The Freudian or psychoanalytic system is the one most widely used by professional practitioners in the field of mental health.

***Did Sigmund Freud say that sex is a major factor in determining a person's character?***

Freud did say that a person's character is largely determined by the way in which he copes with his sex urges during critical periods in childhood. However, sex, in Freud's view, included the total outreach of an individual for nondestructive contact with his environment.

Erik H. Erikson, in *Childhood and Society*, has extended the Freudian theory to show how the individual's way of handling sexual developmental tasks are elaborated into broad relationship patterns. In Erikson's hands, the psychoanalytic system has been expanded beyond a preoccupation with the sexual impulse (albeit broadly defined) into a comprehensive scheme that includes emphasis upon cultural factors and upon interpersonal relationship patterns.

***What is the psychoanalytic system for classifying character?***

It can be understood in relation to the Freudian theory of psychosexual development. According to this theory, every person passes through a fixed sequence of stages. Each person's character tends to

evolve around a conflict confronted in one of these developmental stages. (See *Psychosexual Development in Man*)

***What are the developmental stages and what are the character types associated with each?***

- 1) oral stage—narcissistic character
- 2) anal stage—obsessive-compulsive character
- 3) oedipal stage
  - A. phallic phase—hysterical character
  - B. genital phase—genital character

***How does a narcissistic character develop out of the oral stage?***

The oral stage is the period after birth when the infant is most dependent upon his mother for the satisfaction of his needs. The manner in which he is nurtured determines the amount of trust he becomes capable of feeling toward others. At first the infant, like Narcissus, loves only himself. To the extent that he learns to trust, he extends that love outward to others. Narcissistic character is found in a person who has developed only a minimal capacity to love and trust others, and who instead needs an excessive amount of attention from others. Such a person is incapable of intimate relationships with anyone, but instead may value and strive for the implicit or explicit applause of a crowd. In the film *La Dolce Vita* the actress Sylvia is a narcissistic character. She has become a sex queen in order to receive the adulation of others although she has no real desire for a heterosexual relationship. She loves her own body for the sensual satisfactions it brings her. She makes a close emotional identification with a little kitten hungry for milk, probably feeling more like that kitten than like a mature woman.

***How does an obsessive-compulsive character develop out of the anal stage?***

The anal stage is the period during which the child first learns to gain major control over his own body. In toilet training and in developing the use of his arms, his hands, and his eyes, he learns how to hang on and how to let go. He is confronted with his parents' values as to when he should hold on and when he should let go. He may vacillate between self-confidence and pride on the one hand, and shame and doubt on the other. He may also vacillate between trusting acceptance and angry defiance in reaction to his parents. The obsessive-com-

pulsive character is found in persons who protect themselves from shame, doubt, uncertainty, and anger by exaggerating the values of their parents. They become exceedingly conscientious and particularly meticulous with respect to details. Their lives become oriented toward doing their duty. Their emotionality is inhibited so that they experience very little in the way of feelings. They are typically hardworking but they have very little capacity to relax.

***How does the hysterical character develop out of the phallic phase of the oedipal stage?***

The oedipal stage, in contrast to the oral and the anal, is characterized by the tendency of the child to reach out for sexual relationships with other people. The first persons toward whom the child reaches (usually in fantasy) are his parents. As he resolves the conflict involved in this first outreach, his desire shifts toward members of the opposite sex other than his parent. The first phase (phallic) of this reaching beyond the family is one marked by intrusion in which the individual is out to make conquests. An adult male with such an exploitative pattern is called a Don Juan character. Women may be equally active sexually although they may express it differently through teasing, provoking, or making themselves attractive. In the hysterical character, which is found predominantly among women, guilt is associated with sexual expression, and sexual thoughts tend to be repressed. Such a woman may remain quite provocative sexually although she is unaware of this and tends to be tense and apprehensive about it. Her emotions (other than sexual) are easily aroused. She tends to be both excitable and suggestible. While the obsessive-compulsive character places a high value on facts, the hysterical character is easily swayed by feelings, so that the boundary between fact and fantasy is a vague one.

***What is a genital character?***

Erik Erikson described genitality as the utopia of the Freudian system. The individual with a genital character is one who is capable of achieving mutuality in interpersonal relationships. He has a strong sense of identity, and he is committed to a consistent set of values. Like the narcissistic character, he is able to receive from others but he is also able to give. Like the obsessive-compulsive character, he is able to work but he is also able to play. Like the hysterical character, he is



capable of having strong feelings but without guilt reactions even if these feelings are sexual.

***What is character disorder?***

It is a character structure in which there has been an inadequate introjection of values for social living. This is a developmental defect in which there is little or no sense of distress.

***How does character disorder differ from psychoneurosis?***

In general, the psychoneurotic wants to be good because he has introjected social values. This introjecting also leads to inner conflict, repression, guilt, and anxiety. The person who has a character disorder does not particularly care whether he is good or not. He knows what the social values are and he may be good in order to avoid being punished. But he has not introjected these values and so he has little inner conflict. What anxiety he does have comes from external threat in contrast with neurotic anxiety, which comes from internal threats posed by the conscience. (See *Neuroses*)

***How does character disorder differ from psychosis?***

In general, the psychotic's thoughts deviate from social reality and his behavior may be bizarre. The thinking of a person who has a character disorder is not deviant, nor is his behavior bizarre. It is merely that his actions may not comply with what is expected of him. (See *Psychoses*)

***How does a person who has a character disorder differ from a psychopath or a sociopath?***

A psychopath or a sociopath is a person who habitually behaves in an antisocial manner, such as a criminal, a sexual deviate, or an addict. These people most frequently have an underlying character disorder, but the underlying problem may also be psychosis, neurosis, or organic brain impairment. (See *Psychopath or Sociopath*)

***How does a character disorder manifest itself?***

It manifests itself by the occurrence of unexpected behavior. The person with a character disorder has less capacity for maintaining loyalty to others. He does not abide by commitments to other people or to work of a productive nature. He tends to manipulate other

people in order to attain his own ends. If other people get in his way, he can hurt them without compassion or even feelings of guilt. He has very little capacity for empathy with others. Words, ideas, and ideals do not seem to have the same meaning for him that they have for other people; he uses them like coins to get what he wants from other people. He cannot be trusted to do what he says he will do. He has little ability to tolerate delay and so tends to plunge quickly into action when stimulated.

***How does a person with a character disorder affect the people around him?***

Individuals with character disorders that are not too severe are often very effective in making good first impressions on other people. They tend to ingratiate themselves quickly, but sooner or later their lack of empathic concern is manifested and the people around them get hurt. Some of these people get angry and will have nothing more to do with such a person. Others take a moralistic view and may use punishments in an effort to reform the "offender." Both of these reactions usually develop out of bafflement and an inability to understand the person who has a character disorder.

***Are there different degrees of character disorder?***

Yes, ranging from mild character defects found sometimes even in the conscience-ridden obsessive-compulsive character to the infantile character and the impulsive character.

***What is an infantile character?***

It is a type of character structure in which there is extreme immaturity, childlike dependence on others, and weak impulse control. Often such an individual is a sexually polymorphous pervert; that is, he may engage in many kinds of sexual deviation or perversion, usually at the instigation of others and without apparent preference on his part. The infantile character may express raw primitive fantasies that at times make him appear psychotic.

***What is an impulsive character?***

It is a type of character disorder in which the individual is unable to control his emotions under minor or major stress. He may be given to sudden outbursts such as temper tantrums, sexual frenzies, or

drinking jags. There may be unpredictable assaults upon others triggered off by seemingly trivial incidents. The individual's behavior is in general excitable and ineffective. His judgment is not dependable and his relationship with others is usually disrupted by the unpredictability of his behavior.

***What causes character disorders?***

We do not know for sure. Constitutional factors may play a part that we do not yet understand. Probably the major factors are to be found within family relationships.

Character disorders tend to develop when there is a large degree of mistrust in the parent-child relationship and the child never learns to experience warmth and security with others. Values then fail to be introjected, and inner controls over behavior fail to develop. (See *The Family in Illness and Health; Parenthood and Child Rearing*)

***Can character disorders be treated?***

Yes, but they are more difficult to treat than are the neuroses. This is so because the person with a character disorder feels a minimal amount of anxiety or distress. He does not usually feel that he is sick, hence does not see the need for treatment. He is frequently brought into treatment by someone else (a probation officer, a spouse, or an employer).

***How are character disorders treated?***

The more extreme forms of impulsive and infantile character usually require hospitalization in order to provide the patient with the controls needed on a twenty-four-hour-a-day basis. He may require a treatment period of several years' duration, and even with such extensive treatment the prognosis is not always good.

The milder forms of character disorder are usually treated with out-patient psychotherapy and with psychoanalysis. A step that is often necessary in this treatment is the generation of anxiety, with the result that frequently the person feels worse during treatment than at any time previously. (See *Psychoanalysis*)

***On what does successful treatment depend?***

It depends on whether or not a relationship can be established between the patient and the therapist. It may help if the patient likes

the therapist, but it is even more important that the patient learns to trust the therapist. More than in working with neurotic problems, the therapist working with character problems must be careful to be firm and consistent. The patient may be very disarming and adept at charming others and is very likely to employ his charms on the therapist. The therapist must be alert to such efforts at being manipulated, not only so that he may not be taken in, but also so that he can see in the patient the fears underlying these manipulations.

***Is age a factor in treatment?***

Yes, to some extent it is. Character problems are particularly frequent during adolescence. Even in relatively healthy personality development, adolescence may be a time of turmoil with respect to the crystallization of character and of a sense of identity. Adolescents are especially difficult to treat with the usual forms of psychotherapy, although some therapists report consistent success within this age range. Others have been able to treat adolescents in groups where they learn to define and introject values from their peers.

Beyond adolescence, age is not a crucial factor, although it is probably true to some extent that the younger the adult, the better the prognosis. (See *Adolescence; Group Psychotherapy*)

***Can the same individual have both character problems and neurotic problems?***

This is very frequently the case, although the neurotic person never has the very severe character disorders. Persons having both are more difficult to treat than those with only neurotic problems but are less difficult to treat than those with only character problems.

# CHILD DEVELOPMENT

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## ***What is the field of child development?***

The field of child development is the study of growth and development from conception to adult life, from the relatively undifferentiated state of the newborn (or unborn) infant to the intricate complexity of maturity. This process may be examined broadly, from many viewpoints: thus child development may include biological, psychological, sociological, or anthropological approaches. The following discussion will emphasize the psychological characteristics of development of children, with some attention directed toward the closely related physical and neuromuscular aspects of human growth.

Although one self-evident and traditional task of professionals in the field of child development has been to construct a descriptive account of the behaviors characteristic of children at different ages, there are so many and such wide individual differences among children at all ages that in recent years child psychologists have centered almost all their research upon the genetic or environmental—especially the latter—factors related to the behavior of children. For the most part, child psychologists during the last ten years or more have studied either the concurrent or antecedent environmental circumstances or experiences related to the learning, emotional, or personal characteristics of children.

To study the effects of antecedent conditions on later behavior, research workers commonly search for differing environmental conditions that occur naturally in the population. Since the experiences of infants and children vary according to the environments into which they happened to be born, child psychologists, though usually unable to assign children to experimental groups at random, as in the laboratory, may study the effects of these different naturally occurring experiences on children's behavior. Studies of various methods of feeding, or toilet training, or of parental rejection or nurturance, for example, are usually

investigations of this nature and are possible simply because these methods of parental training commonly vary within or between cultures.

To the extent that the field of child development explores change in behavior over a period of time, it generally is a disciplined, but not an exact, experimental science. Children cannot be reared in laboratories under rigidly controlled conditions. Research workers in child development have often turned to research with animals for more exactly controlled investigation, as well as for investigation into those theoretically significant conditions of rearing that differ from culturally accepted norms of child rearing, although animal studies, of course, always leave unanswered the question of their relevance to human behavior.

Children can, however, be brought into laboratories for short periods of time, and considerable research has been reported on the concurrent conditions related to the appearance of various kinds of behavior, such as the expression of anxiety or achievement. Considerable research has also been reported on the specific conditions underlying the process of learning.

The results of most studies in child psychology yield relationships of a general or statistical rather than of a specific or an invariant nature. Almost never do research studies find that a particular method of child-rearing invariably results in a predictable consequent behavior in the child. There are so many factors—most of them still unknown—affecting behavior, that knowledge of the effect of only one or several of them is not sufficient grounds for extensive explanation or prediction. The researcher can usually at best report that a particular factor has some effect beyond mere chance, and questions such as which individuals are most affected, or under what conditions the effect is most likely to appear, he generally must leave unanswered, or hopefully, for further research to answer.

The researcher usually can study only one or a few variables at one time, attempting to control for as many others as he can. The novelist, biographer, or clinician, however, is bound by no such restrictions and he can—and must—investigate one individual in all his complexity. The sensitive novelist or clinician often may discover, in ways not available to the researcher, significant determinants of individual behavior. The relationships uncovered by the clinician, however, valuable as they have proven to be for theory-building, must be subject to the more carefully controlled study of more than one subject if these relationships are to

fit reliably into a general theory of behavior and its development. The following discussion will lean most heavily on the results—positive or negative—of carefully controlled research into the behavior of children.

***How does one evaluate the development of a baby?***

Regular medical (which includes developmental) observation of babies under one year should be performed at approximately monthly intervals in order to evaluate the progress of the infant. In addition to the developmental observations these visits to the pediatrician provide an opportunity to immunize the baby against potentially hazardous diseases such as poliomyelitis (infantile paralysis), whooping cough, diphtheria, tetanus (lockjaw), and smallpox.

The basic evaluations of physical growth are noted from the baby's gain in weight and growth in length. The baby will usually triple its birth weight in the first year and grow to one-and-one-half times its birth length. In addition regular measurements of the growth of the head are made during these visits. This is an indirect measurement of the growth and development of the brain.

Further evaluations of the growth and development of the brain and central nervous system are made from observations of the behavior of the infant and the testing of his reflexes. Thus, observations of the time of responsive smiling, the ability to control head movements, eye and hand coordination, sitting, crawling, standing, walking, and the development of social responsiveness are all helpful in evaluating the general progress of the baby. These observations have been recorded systematically by Arnold Gesell and other observers of child development so that more detailed studies may be made if there is some indication for this. These more systematic observations must be done by professionally trained workers who are familiar with the circumstances under which the tests should be carried out and who can properly interpret the results.

***How sensitive is the newborn to his environment?***

Studies of the sensory equipment of the newborn provide a baseline for an understanding of his later development and the mechanisms through which he reacts to his environment and to change in that environment.

Within a few days of birth the infant can respond to different degrees of light intensity with the pupillary reflex (widening or narrowing of the pupil in response to light). He can fixate one eye on a light source

within a few hours after birth and can bring together both eyes on the light source after a few days. Not until the fourth week, however, can he fixate upon different objects presented in succession. The ability to follow a moving object appears within the first week and improves rapidly. Infants are most active in dim light, least active in bright light.

From birth, most infants react to loud, sharp sounds, although some who later develop normal hearing show no reactions. These short, loud noises disturb infants, whereas mild, prolonged sounds seem to quiet them. Ability to localize sound appears at about twenty weeks.

Taste and smell are well developed at birth, and the newborn infant is sensitive to touch, temperature, and pain. Light touch generally results in movement of only the touched part, but heavier pressure is more likely to result in general body movement.

A number of studies have shown that infants reared in institutions where there are many babies and few caretakers show deficiencies later in life, both in intellectual and in emotional development. It has been suggested that the factor principally responsible for these deficiencies is the lack of adequate sensory stimulation during the first few years of life. Frequent stimulation of the infant's sensory equipment may be required for the development of a normally functioning nervous system.

#### *Are there consistent individual differences among newborn babies?*

Individual differences in total bodily activity among infants are considerable. Some babies have been shown to be five times as active as others when their movements are measured with objective recording devices. These differences in activity tend to be maintained as the children grow older.

Individual degrees of irritability, of tone and timbre of crying, and of motility and tonicity of muscles are also characteristic of babies. These expressions of emotional tendencies remain fairly stable from child to child over the first three years of life, and even into adolescence.

#### *What are the guiding theories of personality development?*

Although there are now many theories of personality, very few have emphasized, or even speculated about, the developmental process. Almost all theorists have either explicitly or implicitly assumed that personality evolves through the interaction between the growing child and his environment, but few have attempted to specify the process by which the sleeping, eating, crying, active or inactive, sensitive or insensitive infant becomes the animated or somnolent, the gluttonous or



abstemious, the tearful or spartan, the energetic or indolent, the socially acute or gauche adolescent and adult. By far the most detailed and research-stimulating theory of personality development is the "psychosexual" theory of Sigmund Freud.

Freud conceived of infancy and childhood as successive stages of biological development during which libidinal energy is centered in first one and then another area of the body. Normal children, Freud stated, pass through each stage until they reach the mature "genital" stage of development. Overindulgence or frustration of the child's libidinal drives at any stage results in "fixation" at that particular level, and in the consequent inability to move on to more mature levels of adjustment.

According to Freud, the first stage is the oral level (sucking and swallowing). The overindulged child at the first oral level is characterized as carefree, generous, optimistic, and unwilling to assume responsibilities. The child who is frustrated in his oral needs is said to become pessimistic, demanding of help from others, and dependent. The second oral stage is the oral sadistic (biting, devouring) level. Lack of satisfaction at this level results in an adult characterized by ambivalent attitudes toward others. Friendliness alternates with hostility, aggression with submissiveness, love with hate.

The anal stage follows the oral period. Here the libido becomes concentrated upon the process of the expulsion of feces and the clashes with the parents' needs to train the child. The child who is fixated at the anal level of development is dominated by retaining or possessive characteristics as an adult. Frustration at this level results either in "regression" back to the oral stage or in personal characteristics of orderliness and worry about fine details, cleanliness, parsimony, obstinacy, or, in extremity, sadism, or masochism.

The anal period is replaced by the phallic stage (touching, exploring, fantasizing about the genitalia) and the development of the Oedipus complex—love for the parent of the opposite sex. In normal children the Oedipus complex is resolved as the child abandons the cross-sex parent as a love object and identifies with the parent of the same sex. It is through this process that the superego (conscience) is formed and strengthened.

The latency period of middle childhood is a time of libidinal quiescence, during which repression and other psychological "defense mechanisms" appear, and social feelings develop. Puberty brings on the late genital period, a revival of the Oedipus conflict, the develop-

ment of adult modes of libidinal satisfaction, the predominance of homosexual choices, and finally the normal heterosexual choice of the love object. (See *Psychosexual Development in Man*)

Early psychoanalytic theory of the development of personality was derived through the study of adults' recall of their childhood years, but it has led to many investigations with infants and children as subjects, of the areas of feeding, toilet training, identification, dependency, and the growth of conscience and guilt feelings.

A more recently formulated, "neo-Freudian" theory of personality development has been offered by Erik Erikson, who incorporates the stages and fixation aspects of the Freudian theory, while de-emphasizing the importance of organ systems and centering upon problems of social learning.

Erikson suggests eight successive periods of development, each with its "psychosocial crisis" to be resolved by the child before he can move satisfactorily to the next level.

1) *Learning trust versus mistrust*. During infancy the child who is loved and nurtured becomes basically secure and optimistic. The child who is mistreated becomes insecure and mistrustful.

2) *Learning autonomy versus shame*. The learning of bowel control is the prototype of many social lessons during the ages one to four, during which the child may develop either feelings of pride in accomplishment and self-control, or feelings of shame.

3) *Learning initiative versus guilt*. During the preschool years the child learns to develop his social skills with other children, to cooperate, and to be able to lead as well as to follow. The child not able to do this feels guilty, clings to adults, and does not develop play skills and imagination. (See *Guilt*)

4) *Learning industry versus inferiority*. The school age child learns the techniques of self-discipline, the more formal rules of living in his peer group, and the satisfaction of accomplishment. Failing to do this he feels inadequate and inferior.

5) *Learning identity versus identity confusion*. During adolescence a mature time perspective and a sense of achievement develop in the successful person. Although probably most adolescents experiment with minor delinquency, are rebellious, and have feelings of self-doubt, the maturing young adult gradually learns, by trial and error, his stable social role. At this stage the growing and developing youth looks for models to inspire him and for ideals to guide him. (See *Identity; Adolescence*)

6) *Learning intimacy versus isolation.* A successful basis for marriage and lasting friendships depends upon the development of the ability to experience real intimacy. The avoidance of such experiences may lead to isolation.

7) *Learning generativity versus self-absorption.* The successful adult lives productively, in his family as well as in his work life. If the individual is unable to do this, he may become overly self-absorbed.

8) *Learning personality integration versus despair.* The mature adult, having successfully passed the earlier stages, develops independence and security. The adult who remains at conflict on one or more of the lower levels is chronically dissatisfied and never at peace with himself. (See *Creativity*)

***What are the effects of various feeding practices on the child's behavior?***

Advice to parents about the feeding of infants has shifted drastically over the past fifty years. In 1920, for example, most advice-giving articles recommended strict feeding schedules, in contrast to the predominance of recommendations for self-regulatory ("on demand") feeding in 1948. Recommendations have been based upon differing viewpoints of the effects of various feeding methods on many aspects of the child's behavior, including the development of his personality.

What have careful studies of feeding practices found? Breast versus bottle feeding has no demonstrable effect on such behavior as aggression, dependency, feeding problems, thumb-sucking, bed-wetting, or disturbance over toilet training. Research findings indicate that mothers who breast feed feel no warmer toward their children nor more competent in child care, nor are they any happier about having children. In the past, parents with more education tended to prefer bottle feeding; in recent years this group is moving toward a greater preference for breast feeding while those with lesser education are giving it up. From a clinical viewpoint, breast feeding when possible would seem preferable inasmuch as it provides a food uniquely suited for the infant under comfortable feeding conditions.

Although most mothers now follow a rather permissive feeding schedule, about 20 per cent still schedule feedings rather rigidly. These latter mothers tend to be somewhat more anxious about child care, but the fact that their babies were fed on a rigid schedule seems not to affect the development of their children's personalities. The occurrence

of feeding problems similarly is unrelated to scheduled versus "self-demand" feeding practices.

Babies whose weaning is started latest are weaned more quickly than babies whose weaning is started earlier, but there is a tendency for late, severely, or very permissively weaned babies to become more upset over the weaning process than babies weaned early, gently, but less permissively.

***What are the effects of differences in timing and severity of toilet training?***

The range of ages at which mothers begin toilet training children is wide, from before six months to over two years. In general, the later training is started, the quicker it is completed.

Children started in training either early—five to nine months—or late—after twenty months—show little upset over the training process. Children started in the period of fifteen to nineteen months show the highest percentage of disturbances.

Severity in toilet training—the use of punishment or extreme pressure—does not shorten the training period, and in unaffectionate mothers seems to be related to prolonged bed-wetting. Severity in warm mothers has no effect on bed-wetting. A general quality of maternal personality tends to be related to severity of training. More severe mothers demand from their children early conformance to adult standards, are generally more punitive, and do not tolerate counteraggression.

There is evidence, furthermore, that rigidity in training, along with rigidity in other aspects of infant care, results in slower motor development during infancy.

When later effects of toilet training have been investigated, some studies have shown a positive relationship between severe training and the development of aggression and negativism in early childhood, although these results may apply only to boys and not to girls. Evidence for the relationship between severity or early onset of training and the psychoanalytic "anal character" is conflicting, although the postulated traits of "analidity"—obstinacy, parsimony, and orderliness—do tend to occur together.

***How do children develop appropriate sex roles?***

Much of the behavior of children may be attributed not to the learning of specific acts by reward and punishment, but to the adoption of a specific role in society. The child may be said to pattern his be-

havior according to the role with which he identifies himself. Children generally behave in ways that are appropriate to their own cultures, their own families or communities, and to their own sex.

In general, boys identify with their fathers and girls with their mothers. Probably because of the different expectations and reinforcements of the parents, boys as early as their second or third years begin to show preferences for rough, aggressive, and physically more active games, whereas girls tend to play more quietly and more imaginatively.

Boys whose fathers live at home more readily manifest the masculine role, especially when their fathers are warm and permissive. The sons of rejecting, harsh fathers are less inclined to adopt the masculine sex role. Boys also identify more readily with "powerful" fathers (a finding that offers some support to the Freudian theory of the Oedipus complex); these boys behaving in more masculine ways than boys with weaker fathers. Boys thus strongly identified with the masculine role also tend to be seen as better adjusted than boys without strong masculine identification.

The relationship between identification and adjustment does not hold for girls, however. In fact, little clear evidence has emerged concerning the identification process in girls. It is probably a more complex process than it is for boys, and demands considerably more research than is now available.

### *How is maternal behavior related to dependency in children?*

Attempts to relate the experiences of the infant to the development of dependency behavior have not as yet yielded positive relationships. Dependency behavior in early childhood is not related to maternal warmth toward the child as an infant, to breast versus bottle feeding, nor to the age of weaning. Neither the degree of maternal responsiveness to the infant's crying nor separation experiences are related to later dependency.

Mothers' reactions to dependent behavior, however, are related to the amount of dependency shown by the children. Mothers who report that they react to dependent behavior in their children by irritable scolding and by pulling away from them also report higher frequency of dependent behavior. The most dependent children were those whose mothers at first rejected dependent clinging but who eventually gave in to the dependency demands. Which comes first—dependency or rejection—is still a matter of speculation.

There seems to be a general factor of permissiveness related to the

mothers' acceptance of dependent behavior. High tolerance for dependency is related to the parents' warmth, gentleness in toilet training, and acceptance of sexual behavior and of aggression toward the parents. (See *Dependence*)

***How does aggressive behavior develop?***

Aggressive behavior and dependent behavior are related. Children high in dependency also tend to be high in aggression. Both behaviors, however, are related to the degree of total activity of the child.

Boys are generally more aggressive than girls, and this greater aggressiveness may be related to the tendency for mothers to be generally more permissive of aggression in boys and to use more physical punishment (which tends to increase aggression).

Aggressiveness is decreased if parents prevent or nip in the bud the occurrence of aggressive behavior instead of responding passively to it, but only if the prevention is accomplished by control techniques other than punishment. Punishment, especially physical punishment, tends to increase hostility in the child and leads to further aggression at later times, as well as to provide a model for the type of behavior the parents wish to prevent.

Anger is related to the occurrence of frustrating experiences encountered by children in many contexts, and to conditions of fatigue and temporary poor health. The highest frequency of aggressive and angry outbursts occur just before lunch and just before the evening meal, as mothers hurrying to prepare dinner well know. (See *Aggressions*)

***What are the effects of anxiety in schoolchildren?***

Ours has been called the "Age of Anxiety." Certainly, feelings of tension and gnawing fear in the absence of real threat are common among both adults and children, and represent a pervasive problem for research workers and practitioners in mental health.

Recent investigations have approached the general problem of anxiety through the study of the reactions of children in test-taking situations. Children who are anxious when taking tests also tend to show anxiety under other circumstances, suggesting the existence of a general factor of anxiety that tends to arise in some children under conditions of stress. Test-anxious children are likely to blame themselves for failure, and to lack self-confidence.

Test anxiety increases with age, presumably as children's perceptions of adult pressure to succeed become more acute. Girls admit anxiety more readily than boys, but the effect of anxiety upon their performances is not so clear-cut as it is for boys. There are no social class differences in anxiety level.

Highly anxious schoolchildren tend to receive low scores on standard I.Q. tests, but perform better when the test is structured as a game rather than as a test. Tense children also do not do as well in problem-solving as nonanxious children of similar I.Q. grade and sex. Anxious children perform most poorly when they do not know what is expected of them and when they are required to function independently. However, anxious children may perform better than secure children when they receive direction and nurturance.

Mothers of anxious children are more psychologically defensive than mothers of secure children, and they apparently maintain a somewhat less realistic perception of their children than do the fathers of the anxious children.

Highly anxious children are likely to be unpopular in school, and frequently tend to withdraw from social contact with other children. When such manifestations occur, psychiatric consultation for the child and family may be desirable, since with competent professional help the anxiety may be reduced and the child enabled to function more effectively. (See *Childhood Emotional Disorders; Anxiety*)

### ***Do parental attitudes affect the social behavior of children?***

A "syndrome analysis" of many specific aspects of parental behavior has yielded three primary clusters—the syndromes of democracy, indulgence, and rejection. Investigation has revealed differences in the behavior of children reared in these three different home environments. This study shows that in the preschool years children from democratic homes—that is, those homes where there is emphasis on the children's potentiality for development and where the children are permitted to help determine family policies—tend to be aggressive, fearless, and planful, with leadership abilities, but also tend to show some cruel behavior. Children from indulgent homes tend to be found at the social extremes of both very friendly and very quarrelsome behavior. The rejected group seems mainly characterized by resistance to adults.

When the children reach school age, children from democratic homes are found to be friendly, popular, secure, and to be leaders. Indulged

children are shy, and rejected children tend to be quarrelsome and to resist adults.

Other studies of parents' attitudes and behavior toward their children have resulted in the discovery of similar clusters of parental behaviors and have found similar relationships to the behavior of the children. (See *Parenthood and Child Rearing*)

***How do the ordinal position, sex, and age difference of their siblings affect the personalities of children?***

The child's behavior is likely to be affected in various ways by the social position he holds vis-à-vis the positions of other significant persons in his life. His relationship to other children is one such important variable in his development, and of all children his brothers and sisters are likely to exert the greatest influence upon him.

The following results have emerged from a study of the personality patterns of five- and six-year-old children in relation to ordinal position (first born or second child), sex, and age spacing of siblings. It is likely that at close age spacing (one to two years) these results can be attributed to the sibling's direct effect upon the behavior of the child, whereas the effect is likely to be indirect, manifesting itself through differences in parental behavior, for siblings far apart in age.

Firstborns tend to be more self-confident and to have fewer nervous habits (grimacing, nail-biting, etc.) than second children, but second children are less hesitant to express anger. Firstborns at the close spacing recover less readily from upsets than second children.

Particularly at the two- to four-year sibling-age-difference level, the child whose sibling is of a different sex is more self-confident, cheerful, active, healthy, less vacillating, and more inclined to recover poise easily. These differences have been interpreted as suggesting a greater degree of stimulation between members of pairs whose sibling is different in sex than between members of pairs of siblings of the same sex.

Differences in personality related to differences in age spacing are greater for boys than for girls. The two- to four-year spacing, especially for firstborns, seems to be more stressful than shorter or longer age-spacing. Firstborn boys of the two- to four-year age spacing are more confident, emotionally intense, excitable, moody, angry, and decisive, and more given to alibiing, projecting of blame, and indirection, than boys whose siblings are closer or more distant in age. (See *The Family in Illness and Health*)



***Can parents influence their children's motivations to achieve?***

The behavior of children at home, in the community, and at school, is affected by the character and strength of their motivations. Motivation, or drive, energizes behavior by putting the child into a state of increased activity, and sensitizes behavior by increasing his perception of, or attention to, selected aspects of the environment. The child motivated to achieve is characterized by a high level of energy directed toward the acquisition of particular goals, by his need to succeed, and by narrowed concentration upon those aspects of his environment that will help him reach those goals.

Motivation to achieve in school contributes significantly to actual achievement, interacting in complex ways with native ability. The bright child with low academic achievement motivation is known clinically as an "underachiever," and presents serious problems both to the individual and to the full utilization of talent in our achievement-oriented society.

Studies of children of nursery-school age, in school and at home, and studies of their interactions with their mothers found that (1) children who strive to achieve are less dependent on adults for help and emotional support; (2) the behavior of children in seeking help from adults, seeking emotional support, and seeking approval, and their efforts to achieve, are moderately consistent from home to nursery school; (3) mothers who frequently reward achievement efforts are less nurturing, but equally affectionate with their children, than mothers who do not reward achievement; and (4) neither maternal affection nor independence training are related to children's achievement behavior, but direct maternal rewards of achievement efforts and seeking approval are. (See *Schools and Mental Health; Motivation*)

***Which is more important, heredity or environment?***

This question has plagued psychologists and others for centuries. In extreme cases, the influence of either one or the other is unmistakable. Children who are born severely retarded mentally, cannot, even with the best training, rise above a relatively low level of intellectual functioning. Normally endowed children severely deprived of sensory stimulation during infancy develop with lower I.Q.'s and with more emotional problems than equally endowed children raised in normal homes. In the vast middle ground of normal endowment and environment, however, the controversy rages. Although researchers will prob-

ably continue to search for solutions to the problem, most child psychologists now accept the view that a complex interaction between learning and maturation always underlies the development of behavior.

Many research workers step beyond the question of maturation versus learning to ask, instead, "What are the limits imposed by maturation?" and "Can special training accelerate the development of certain behaviors?" Particularly, psychologists ask, "Are there special stages of maturation during which learning may be especially effective?" and "Are there behaviors that can never be learned after a certain maturational stage has been passed?" Several psychologists have suggested the existence of "critical" or "sensitive" periods for learning, in the life of the child. Educators seek the "teachable moment." Teachers, e.g., delay teaching reading skills until children show signs of having matured into the stage of "reading readiness."

Results of the famous study of Johnny and Jimmy (fraternal twins) suggest that activities like sitting up and walking are little affected by practice, whereas more specialized activities like roller skating and tri-cycle riding may be fostered and improved by extra practice (Johnny had been encouraged and helped to practice all activities in which he showed some interest for almost two years; Jimmy received no special training).

In general, it may be concluded that maturation offers opportunities and sets limits for the influence of environment. For the child those limits may be broad indeed. (See *Learning and Reading; Learning and Reading Disturbances; Heredity and Mental Health*)

### *Can the I.Q. be changed?*

I.Q. levels of children may be affected by differences or changes in environmental circumstances. Identical twins (with hypothetically equal endowment) are very similar in intelligence when reared together, but identical twins reared in very dissimilar environments have I.Q.'s that differ markedly from each other. Children living in highly impoverished physical and intellectual atmospheres generally show declines in intellectual functioning as they grow older. However, children from similar poor environments who are given special attention in nursery school, or who attend better grammar schools, show general increases in I.Q. level. Preschool experience, even among children from middle-class homes, tends to increase I.Q.'s.

Poor health among children often will lower I.Q. level, and improve-

ments in nutritional status of young malnourished children will raise I.Q.'s significantly. (See *Intelligence; Intelligence Testing*)

***What significance do child development studies have in the field of mental health?***

It is the practice of professional workers in the field of child care to look to child development for information that can be communicated to parents and child-caring agencies in order to help them rear children with greater mental, as well as physical, health. Thus, research studies in child development may be viewed as providing the basic scientific data from which pediatricians, psychiatrists, and other physicians, dentists and the other health professions, psychologists, child welfare workers, social workers, nutritionists, recreation workers, and educators may base their practices.

It is too early to expect that basic research in child development will have immediate and practical implications for mental health. Certainly, however, from the study of early parent-child relationships, early speech and learning patterns, early disturbances of behavior and their consequences for the later development of the child, professional workers should become increasingly effective in helping parents rear their children to be mentally healthier. The difficulty in defining clearly the objectives of each family in child rearing—and, indeed, in clearly defining mental health—makes this a formidable challenge for parents and for professionals in this field.

The significance of the long-term follow-up of children studied is apparent if any evaluation of child rearing practices is to have meaning. Several child development research centers have, therefore, undertaken long-term studies of families and their children from the prenatal period to maturity. It can be readily appreciated that such studies are extremely difficult and costly, hence cannot be undertaken by many research groups.

Some observations of child development have had practical implications for the care of infants and older children. It has been observed that infants in the second half of the first year of life may react to separation from their mothers (such as in long-term hospitalization or institutionalization) by apathy and a depressed appearance and ultimately by failure to gain weight and to thrive. In more recent years, under such conditions of separation, it is noted that if considerable stimulation is provided for the infant, such deterioration tends not to occur. Thus, if babies are removed from their natural mothers it is important to

provide stimulating substitute maternal care. Also, in recent years it has been noted that a similar state of failure to thrive may occur in a baby who is under the care of its natural mother when the mother cannot intimately care for and stimulate her baby. These observations have considerable implication for child-caring agencies that, because of some disturbance in the natural family, have the responsibility of caring for infants and young children.

# CHILDHOOD EMOTIONAL DISORDERS

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***What are the major emotional or psychiatric problems with which child psychiatry deals?***

Children's psychiatric problems are primarily seen as changes in the usual patterns of activity, or in disturbances of body functions such as sleeping, eating, or elimination. Most psychiatric symptoms of children are easily noticed by those around the child and, when discovered early can be readily corrected. Any change in activity—such as restlessness, a great deal of crying, unusual quietness, prolonged irritability or petulance, continuing fearfulness or difficulty in sleeping—may be a reflection of emotional turmoil in the child. These are easily recognized signals of the beginning of emotional turmoil, and it is fortunate that the child can freely show them, for it is then possible to attempt to correct their causes. In adults these early signs are often kept “inside,” and it is only at a much later time when the disturbances in activity have set into the cement of symptoms that help is sought. There is another group of childhood disorders, far more serious, and relatively infrequent. These are seen as serious personality distortions that prevent the child from living any kind of normal life or having normal school experiences.

It is not usually recognized that infants have emotional tensions and disorder, because they are able to express them only in very limited ways. As the child becomes older, his expressions of emotional disorder become increasingly similar to those seen in adults through worries, feelings of depression or consciously experienced and communicated anxiety, and disturbed thinking. The infant and the young child express their emotional tensions through the psychological and bodily functions available to them, and those functions that are in process of development are most likely to be the seat of problems.

In the young infant the possibilities for expressing emotional tension

are very limited indeed, and they include disturbances in the usual patterns of sleep, in feeding difficulties such as regurgitation and diarrhea not caused by infection or organic malfunction, in severe colic, and either great increase in activity or unusual quietness. These problems can certainly continue throughout childhood and adulthood but often have their beginnings during infancy. Excessive or unusual crying is another signal of emotional disorder in young infants and children.

During the first several years of life, difficulties in establishing bowel and bladder control reflect emotional disorder, particularly when these functions do not come under fair control by the fourth year. Very late development of speech or the development of stammering, stuttering, and other disturbances may reflect emotional difficulties. As the child begins to become involved with other children and adults, problems of anger, competitiveness, and jealousy are seen in a more definite form.

At about three years of age and afterward, children are able to express fears in words and can describe the very frightening psychological concerns they have. As the child develops control over his arms and legs and becomes increasingly curious, difficulties about destructiveness, running away, and fire-setting are sometimes seen. Though there are many other symptoms of childhood emotional disorder, this short description may reinforce the idea that the problems worked on most immediately by the child, and certainly by his parents, are those that are most likely to express evidence of emotional disturbance. Sometime between three and six, many children express direct interest in their sexual parts and even attempt to explore the sexual parts of other children. Excessive sexual curiosity or masturbation are sometimes seen as aspects of emotional difficulties.

Some of the earliest signs of emotional disorder (and they can persist throughout life) are shyness, withdrawal, and fear of being separated from a loved one. These are seen in children who refuse to be taken care of by anyone other than their mother; in children who have difficulty in separating from parents at night in order to go to sleep; in children who are fearful of going to school alone or taking on almost any new situation. They can become the shy, inhibited children who are later seen as persons with important emotional difficulties.

It should be emphasized that almost any of the symptoms described here are "normal" when they occur at the time that the particular function is developing or coming under control. For example: most young infants have irregular patterns of sleep; fear of strangers is a

usual part of infancy and of the first experience with new situations in older children; most children show some sexual curiosity; there is a considerable range in the time when children are able to use speech effectively and easily; almost all children show anger and competitiveness with siblings. The important question is whether the symptoms are present only during the weeks or months of development of the particular function and/or in relationship to particular periods of stress, or whether they persist and become even more severe as the months pass. Just as many adults become sleepless, or irritable, or lose their appetites in periods of stress, but then return to their usual patterns when the stress is no longer present, so children function in the same way.

For example, a five-year-old boy who had been toilet trained, began to wet his bed at night and to demand his mother's full attention in a most exasperating way after the birth of a young sister. With his mother's warm and repeated assurance of her love for him and of his importance in the family as a fine five-year-old boy, together with her firm discouraging of his clinging patterns, he reverted to his previous healthy state within several months. This would be considered a not unusual reaction. If, however, the boy continued these patterns over a period of many months, the symptoms would be viewed more seriously and the boy would probably need professional help. Similarly, children go through transient periods of stuttering, powerful reactions of jealousy, or episodes of quietness and seeming depression.

### *What are the causes of these problems?*

Most childhood disorders are the result of imbalances in the relationship between the parents and the child or of experiences that the child cannot understand and that result in fear and anxiety. Inborn factors and complications during the birth process are the causes of a small proportion of the emotional problems of children. In addition, severe infections, which rarely result in inflammation of the brain, and very serious injury of the brain due to accidents, contribute to emotional and psychiatric disorder. (See *Mental Retardation*)

The great majority of emotional disorders, however, are the result of missed cues about the needs of young children on the part of the people taking care of them. These missed cues occur often despite the best and most loving attempts of parents. They consist of "over" and "under" problems: a parent who recalls a particularly stark childhood may give in to a child's wishes far too often, spending hours in feeding

him or being too sympathetic to his complaints, thus being "overprotective"; a parent who is deeply involved in his own work or outside activities may unwittingly ignore the child's needs for cuddling and warmth and parental play, and thus "understimulate" a youngster, thereby setting the stage for a quiet, withdrawn, depressed child; a parent, recalling that as a child he didn't have enough discipline, may be "overly strict" and move his child in the direction of fearfulness, tension, and a feeling of unworthiness.

It is in the disturbances of regulation of the following that most disorders occur:

*Limits:* the amount of activity allowed to the child, that is, the amount of discipline given to the child, and the amount of freedom permitted him, as opposed to the amount of conformity expected of him.

*Love:* the amount of warmth given to the child, and the amount of cuddling, playing, and sharing with him—opposed to his need to see himself merely as part of the family rather than as its whole focus; the need for respect for the privacy of the parents.

*Life experiences:* the willingness to let the child act on his curiosity and to give him freedom to try new things, even where some slight danger might ensue; the need to inculcate the essentially optimistic and interesting aspects of life rather than its forbidding side. (See *Parenthood and Child Rearing*)

These major guideposts of life development are particularly important in the first years of a child's life because his major patterns of activity are set during that time. Though it is possible to change patterns at a later time, the early ones have particular importance and power. The young child goes through crucial points of development and any serious trouble at these points will often be reflected as symptoms at a later time. Such points include the setting of patterns of sleep and feeding in infancy and early childhood, the development of walking, hand activities, and other phases of muscular control, regulation of patterns of elimination, the development of speech, the developing comfort of being alone and increasingly independent in the world, and the early organization of learning patterns. The child's feelings of comfort with parts of his own body and his feelings of acceptance of all the functions of his body are organized by his experiences early in life. (See *Child Development*)

A small proportion of children's problems are the result of actual damage or faulty development of the brain. Brain disorder can accen-



tuate any of the difficulties noted here and also causes special problems such as serious distortions in thinking, most unusual and persistent fears, unusual body motions, greatly disturbed patterns of getting along with others, and major blocks in learning.

*Are children's problems different from those of adults?*

Because of the great amount of growth still to occur in children, many of their problems leave no lasting, serious imprint, just as a slash on a young tree is quickly covered over by new growth. Children also bounce back more quickly and easily from emotional difficulties than adults do. As they become stronger and have better mastery of their environment, they are less at the mercy of fears that might have been crippling for them earlier. The deeply set neurotic problems of adults are less often seen in children and are usually not so severe. In addition, the very serious mental illnesses of adulthood, such as schizophrenia and manic-depressive psychosis, are very rare in children. Naturally, sexual difficulties, which are so important in adults, are not seen in their fully developed form in children. (See *Psychosexual Development in Man; Adolescence*)

Children do become depressed, though they are unable to be as precise as adults in expressing feelings of unworthiness, hopelessness, and lack of competence. Depression in children is expressed more in withdrawal, or in bodily symptoms such as pain, or in crying. The "unhappy, shy child" is often a depressed child who can't express himself about his depression. Again, because of the resilience and growth potential of children, periods of depression are covered over by the new challenges and possibilities of feeling older.

*Are there any emotional or psychiatric problems that seem to appear only or mostly among children?*

The psychological diseases of infancy, expressed in serious sleep disturbance, regurgitation of food, and continuous irritability are the unique expression of the immature infant's tensions. They express, before words or gestures are available, the infant's feeling of tension and emotional disturbance. Later, enuresis (bed-wetting) and encopresis (soiling) are unique to children and young adolescents. Very few adults continue to have these symptoms except in states of severe mental illness. These, too, are distortions of the developmental process and tend to be replaced by other symptoms once the developmental process has been completed. The effects of moderate or mild brain damage are seen

most dramatically in children. Such children have difficulty with the coordination of their arms and legs, develop unusual learning habits such as reading backward or upside-down, and often show a great deal of motor activity, being in motion almost all the time.

Finally, "early infantile autism"—a disorder in which children stay by themselves, refuse to be involved with adults or children, have powerful needs to keep all the aspects of their environment the same, and often develop bizarre views of the world—is a disturbance characteristic of children. Behavioral problems, such as tantrums, refusal to eat, and fighting, become less apparent as the child grows older. This is because society is very critical of these manifestations, and also because the child gets a broader view of himself and becomes more self-conscious as he grows older. However, these problems do continue to be present in some older children and adults.

***Who is qualified to recommend psychiatric help for a child?***

There are many people skilled through experience or training to recognize psychiatric problems in children and to refer them to a psychiatrist for diagnosis and planning. These people include the parents of the child, as well as nurses, nursery school teachers, social workers, psychologists, and pediatricians or other physicians. Each brings his characteristic view to bear. Since emotional difficulties can coincide with physical difficulties, it is well that a psychiatrist make the decision about the planning for a child with emotional symptoms. He often will work in collaboration with another physician to study all the possibilities of causation of difficulty. Some schools and other organizations have teams of skilled people such as counselors and psychologists who have a great deal of experience in the identification of emotional problems in children. These people are very helpful in arranging for the referral of children to psychiatrists.

It should be kept in mind that referral for psychiatric help is a referral for an assessment of a child's difficulty, not necessarily for ongoing treatment. Often, a psychiatrist can make immediate suggestions that will be helpful in righting a situation, or be able to consult with people in the youngster's school in ways that will help the child. This is why we use the term "psychiatric study" or "psychiatric evaluation" rather than psychiatric treatment, when a child is referred. Often a prolonged period of regular psychiatric treatment is indicated, but this is not always so.

*How is treatment conducted in child psychiatry?*

Treatment in child psychiatry consists of a regular period, usually about one hour, occurring once (or more times) weekly with a psychiatrist in a room especially fitted with toys that reflect everyday life situations and potential areas of difficulty. For example, there are family dolls, animals that represent life situations, and blocks or models to be constructed. There are toys that offer a possibility for aggression, such as guns and darts. There are toys reflecting illness possibility, such as a doctor's bag and instruments. There are telephones and paper and pencils for facilitating communication. There are no toys merely for play, but rather to open up areas of worry and trouble that need to be worked out. Inasmuch as play is the child's work, the use of play is the method for discovering and clearing up his difficulties.

The doctor and the child work together to understand the bases of difficulties. For example, a child who makes a doll represent a lost and lonely child put out of the house by a bad mother, will be encouraged to explore why he feels this has happened and what can be done about it.

The relationship between a psychiatrist and child patient is one of trust, privacy, and respect. The psychiatrist doesn't divulge any of the intimate details of the work in the playroom. He saves a particular, regular appointment time for the child. The doctor does not ask questions as such, but instead helps the child to play out situations in ways that can help both of them to understand the causes of difficulty. It is necessary for the doctor to be warmly involved with the child, but he never has to "give in" to the child or merely be a "nice person." This kind of treatment is not frightening for children except insofar as the uncovering of difficulties in their lives is frightening. Just as some pain occurs in having teeth pulled, sometimes pain occurs in the course of psychiatric treatment. The doctor doesn't try to put thoughts in the child's mind, but rather to find out what thoughts, particularly disturbing ones, are already there.

Parents must be prepared for finding the child occasionally upset in the course of treatment and not wanting to continue treatment, or, on the other hand, turning away from his parents for a period of time during treatment. It is often necessary for parents to work with a professional person while a child is in treatment in order for them to keep current on the present status of the child's difficulties and to get help in the organizing of the child's life. With young children the period of

treatment is often forgotten or remembered only vaguely after problems are resolved and they are again living comfortably. (See *Child Psychiatry*)

***What problems does the child face after successful treatment?***

Psychiatric treatment helps to regulate or modify a child's behavior and thinking patterns. After successful treatment, a child is ready to face the usual problems and challenges of life. He carries some insurance and advantage from treatment in that he is more sensitive to the importance and meaning of relationships between people as a result of the investigation involved in psychiatric treatment. However, psychiatric treatment doesn't confer immunity from further emotional difficulties or complications. Psychiatric treatment is more like the setting of broken bones. It helps the bones to knit, but they can be broken again.

Children who have undergone psychiatric treatment do not have "morbid" concerns about themselves, they are not less responsible than others, and they have no unusual preoccupation with sexuality. These are myths without basis in actual professional experience.

***How does child psychiatry serve the purposes of general research into human behavior?***

Since the great bulk of emotional difficulties in human beings is the result of inborn problems or developmental difficulties during the early years of life, child psychiatric work is the best laboratory for the study of the origins of psychological difficulties. During the time the child is so vulnerable and changing, one can accurately see the effects of various experiences on him and have the opportunity to study the long-term results of these influences. Later, experimental or therapeutic change in a child's environment can be assessed for its long-term effects. In another sense child psychiatry has a unique place: although the emotional symptoms of adults are quite complex and seemingly inexplicable at times, their earlier determinants can be studied easily through the observation of children. Just as it is difficult to visualize all the interactions between rain, sunshine, chemicals, and soil in the development of an already full-grown tree, so it is difficult to visualize the myriad processes involved in the development of an adult. However, if one can observe each process as the young tree is growing, a great deal can be learned.

***What are the diagnostic procedures in child psychiatry?***

Parents know their child best, and it is necessary for the psychiatrist or a colleague to speak extensively with the parents about the child's development, his physical health, friendships or difficulties with other children, and school experiences, in order to understand the child. The psychiatrist then has a diagnostic interview with the child in a playroom in which various aspects of the child's conflicts and worries can be played out through the special toys available. The psychiatrist often uses the services of a psychologist, who studies the child's developmental status and intellectual capability and gets some idea of his inner thinking and concerns through special tests. The psychiatrist frequently needs a medical evaluation of the child in order to have a complete picture of the problem. Following this, the parents meet with the psychiatrist to discuss the findings and suggestions that arise from the study. The findings may suggest that regular treatment is necessary or that particular procedures be changed at home or in school in order to benefit the child. (See *Psychodiagnostic and Personality Testing*)

***How many emotionally disturbed children are being cared for in clinics, hospitals, etc., or privately in the United States? How do these figures compare with those of other countries?***

Though it is certain that childhood emotional disorder is a considerable problem in our country, there are as yet no comprehensive surveys of its true extent. However, we do know that at least 100,000 children begin treatment in the approximately 1,500 psychiatric clinics in the United States each year. More than 3,000 children with severe emotional disturbances are treated in hospitals or residential treatment centers each year. These figures are very conservative and do not at all include the number of children who are treated in private practice. We do know that many more children are treated in clinics or in private practice than are hospitalized for treatment. This is in contrast to the treatment of adult mental disorder, where the number of patients treated in hospitals is approximately 500,000. Research into the extent of emotional disturbance in children, whether or not treated, suggests that 10 to 15 per cent of our child population has emotional difficulties of a serious enough nature to require treatment.

Almost all children at some time or other in their development have emotional crises that merit special professional attention in order to keep them from becoming more serious, and many more facilities are needed to handle these acute "stormy periods."

It is impossible to compare United States' rates of emotional disorder in children and facilities for treating these disorders with those found in other countries. However, from clinical experiences in Europe, it seems that we in the United States have more and better facilities for treating the acute problems of children, outside of hospitals, although we have neither better nor more extensive organization of hospital treatment centers for them.

It is because of the recognition throughout the world of the immense need for psychiatric programs that mental disorder is considered to be one of the major health problems we now face. (See *Residential Treatment for Emotionally Disturbed Children*)

# CHILD PSYCHIATRY

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## *What is child psychiatry?*

Child psychiatry is the branch of medicine that deals with disturbances in the mental and emotional development of the young from infancy through adolescence. It is concerned with the correction of unhealthy or distorted patterns of personality, character, adjustment, and habit (undesirable rather than distorted or difficult). It not only includes diagnosis and treatment of already established disturbances, but it also is interested in understanding the hazards to normal emotional adjustment and development so that appropriate preventive approaches can be made. The work of child psychiatry is conducted by physicians who, following their training in adult psychiatry, have obtained specialized training in the psychiatric problems of childhood and adolescence.

## *What is its history?*

Until the middle of the nineteenth century, there were only occasional people who had children under their care, and who developed skills in working with the personality distortions of these children. The only recorded indications of this came from novelists like Nathaniel Hawthorne who, in their writings, showed a perceptiveness of children's feelings and of what could be done to help children get through difficult adjustment periods. In the 1850's, work with handicapped and ill children led a few people, such as Charles West, who founded the Hospital for Sick Children, Great Ormond Street, London, to present some organized thinking and teaching about the habits, adjustments, and feelings of children. Likewise, in the field of mental retardation, there was a growing awareness of childhood difficulties and there were periodic organized attempts to present in writing the slowly collecting observations about emotionally based disturbances in children.

In the early 1900's, as psychoanalysis began to see that the roots of adult psychiatric problems are in childhood experience, there was a

sharpening of focus on this period of life, from both the informational and the corrective points of view. Hermine von Hug-Hellmuth began the first experiment in definitive treatment of children's emotional disorders with "play therapy" about which she wrote in the early 1920's. In the United States, William Healy in 1909 established the pioneer child-guidance clinic, although the term was not coined until 1922, when the diagnosis and treatment of psychiatric problems in children had developed rapidly. Anna Freud and her group were developing psychoanalysis for children in Vienna, and in Germany a group centering around August Homburger began organized psychiatric work with children. In 1930 Leo Kanner established a liaison clinic between pediatrics and psychiatry at Johns Hopkins.

From all these beginnings child psychiatry has continued to grow, to a point where it has been officially recognized as a subspecialty by the American Board of Psychiatry and Neurology, Inc., which now conducts accreditation examinations in child psychiatry. (See *Mental Retardation*)

***How does child psychiatry in the United States differ in method and scope from its practice in other countries?***

In the United States the influence of William Healy and his followers was the predominant one in providing patterns of diagnosis and treatment. From his clinic grew the child-guidance clinic movement centered around the clinical team. This group was strongly influenced by psychoanalytic principles, and dynamic psychiatry, therefore, became the basic orientation. There was a parallel growth, although not so extensive, in the pediatric-psychiatric field. These movements were supported by foundations and funds which greatly accelerated their spread and acceptance.

In Europe, child psychiatry tended to grow more from the organic orientation of causality, except in England, where the psychoanalytic approaches under Melanie Klein flourished. Later the child-guidance approach reached England and has spread, particularly since World War II. Since that time the organically based approaches to child psychiatry have predominated in the rest of Europe. There are indications, however, that, as there is increased communication between countries, especially that growing out of the exchange of trainees, more of the dynamic psychiatric concepts are being put into practice in Europe, and more of the organic approaches are being made available and combined with the dynamic in the United States. In the Union of



Soviet Socialist Republics, Pavlovian principles have tended to dominate the concepts of causality and treatment, although there are indications that modifications along more dynamic lines are replacing the exclusively neurophysiological behavioral conditioning and somatic approaches.

***How many psychiatrists and other mental health personnel are concerned with child psychiatry? What are their specialties?***

At present there are about 250 child psychiatrists who have been accredited by the American Board of Psychiatry and Neurology, Inc. They represent about one-eighth of the psychiatrists who have some degree of training in work with children. Because of the obvious discrepancy between the demand for services for the emotionally disturbed child and the available number of fully trained child psychiatrists, a great deal of the work with children must, of necessity, be done either by psychiatrists who have a knowledge of child psychiatry, but who have not necessarily had "approved" training in it, or by others in the behavioral sciences who have been brought into training to work with children's problems. Specifically, the clinical psychologist and the psychiatric social worker were brought into the clinical team that worked in the child-guidance clinic setting and thereby gained skills that allowed specially talented people in these disciplines to enlarge their horizons to include specific work on children's problems. Usually such persons work under the supervision of a child psychiatrist, particularly where it concerns treatment approaches.

However, many of the problems that children have are of a sufficiently superficial nature so that specially trained people are not necessary in working out these problems. Therefore, orientation and training in dealing with problems of a superficial nature have been offered to pediatricians, schoolteachers, the clergy, nurses, and those disciplines that work with specific handicaps in children. Such training is usually in the hands of a child psychiatrist and/or other members of the clinical team.

***What organizations are concerned with child psychiatry?***

Child psychiatrists were active in the formation of the American Orthopsychiatric Association, which became the forum for the exchange of work and ideas of members of clinical teams. There also was developed a section on child psychiatry in the American Psychiatric

Association, and child analysts had a similar committee in the American Psychoanalytic Association. Subsequently, the American Public Health Association established a section on mental health and the American Medical Association established a Council on Mental Health, all of which actively included child psychiatrists. However, in the early 1950's it became apparent that child psychiatry needed a specific group to be its official representative body, and the American Academy of Child Psychiatry was formed.

***What facilities are available for the care and treatment of emotionally disturbed children?***

It has become an accepted standard that clinical services for emotionally disturbed children are an important part of the public health facilities of the community. Thus, on both public and private bases, a system of child-guidance services has developed in community clinics throughout the country. In our large cities, child psychiatry services are usually also available on a private basis, although they are in short supply.

Residential treatment centers have been developed for those children who require more intensive treatment away from home. These should be distinguished from the "training schools" or rehabilitation centers for youth who have committed crimes, although the more enlightened, corrective approaches in such centers are including psychiatric care. The more disturbed children usually are in psychiatric hospitals, and an increasing number of these hospitals are providing special facilities for severely emotionally disturbed children, including psychotic children.

For the less disturbed child who can remain in the community, special facilities are being pioneered in school systems that have classes for emotionally disturbed children, in the development of day care and treatment centers and, more recently, a movement toward providing group treatment approaches to the preschool child in therapeutic nursery schools. All this is in addition to the services available for less disturbed children and children with psychosomatic illnesses, etc., who can be dealt with by those pediatricians or family physicians who have an orientation in personality development and the awareness of the things that can go wrong in it. Some psychiatric social workers and clinical psychologists with special talents or skills, usually working under psychiatric supervision, provide private treatment for disturbed children. Child analysis is available in a few large cities, but it is in

even shorter supply than any of the other treatment approaches. (See *Residential Treatment for Emotionally Disturbed Children*)

*Is there an adequate program in this field?*

At present, there are no more than token facilities and professionals available to meet the total needs of emotionally disturbed children. The Joint Commission on Mental Illness and Health has strongly recommended that training be given to others in the helping professions so that they might take care of the needs of those children who have superficially based emotional problems, and thus make more services available.

*What should be the attitudes of the family, the community, and the school toward a child's psychiatric treatment?*

The family's attitude toward a child in treatment should be one of real cooperation with the treatment center, with the parents, in particular, considering themselves as part of the treatment team—working with, providing information for, and carrying out the suggestions of the therapists and their co-workers. To be avoided are any attitudes or implications that because a child is in psychiatric treatment, he is therefore “crazy.” It is not uncommon for parents to feel in a competitive position with the therapist, because warmth and closeness are encouraged by the therapist as part of the therapeutic approach to reaching the child's problems. However, the attitudes and approaches are in no way to be interpreted as replacing the parent. Also, the corrective suggestions of the treatment team are not meant to be critical of parents nor to create guilt in them about their possible role in the child's difficulties.

The community, too, needs to think in terms of avoiding attitudes of suspicion toward the child whose parents are sufficiently enlightened to obtain treatment for their emotionally troubled offspring. Logically, the public should feel increased confidence in parents seeking and getting such treatment for the afflicted, because they are “smart enough” to heed the signals when difficulty appears, just as they would for any other pain or medical condition that is indicated. The community, unfortunately, still has a tendency to attach a stigma to the person who has obtained such treatment.

The school can logically think of itself as a beneficiary when a child who has emotional difficulties receives psychiatric help. The school

can be a most helpful participant and collaborator in the work of the treatment team. The school, too, must avoid placing a stigma on the child because he has been placed in treatment. However, the school has even more important roles than that of cooperation. It has the opportunity and the responsibility for finding cases that might otherwise be neglected. The school can be an excellent referral center, and the more enlightened school systems have their own mental health services. These services should not be confined to diagnosis and treatment of learning disabilities, but should be extended to cover the mental health of the child, which is just as important as his physical and intellectual health, and, indeed, cannot be separated from them. All this points toward the need for teachers and principals, as well as school nurses and school physicians, to become oriented in the subject of personality development in children and in the distortions that are possible. (See *Schools and Mental Health; Schools: Mental Health Services*)

At the very beginning of therapy the child should be told that his psychiatric treatment is not just visiting a playroom for fun, but that it has a specific purpose and goal. In other words, the situation would be no different from that of any medical procedure that is disliked by the child but is indicated and necessary. It should be added that it is a fallacy to think that child psychiatric treatment will, of necessity, be painful to children and, therefore, that considerate parents should hesitate to expose the child to such hurt. The opposite is usually true. The child finds that the play techniques, which are the child psychiatrist's tools of diagnosis and treatment, are not only pleasing and well known to him, but that he usually looks forward to participation once he knows what is involved.

***How successful have the various treatments been in child psychiatry?***

Treatment varies with the type of problem presented by the child and his family, the availability of personnel, distance of the family from the services, and financial considerations in some cases. The outlook for treatment of the more superficial problems based on crises in development or temporary situations is quite consistently good. These make up 80 per cent of all the problems in childhood. The child doesn't just "grow out" of a problem, but works out better answers to the problems that arise from new stages of personality and physical development.

The outlook for treatment of the more severe problems, particularly when the child has psychotic responses, is more pessimistic, because facilities for appropriate treatment of these more severe problems are scarce, and because there needs to be better understanding of these problems.

The middle group, consisting of moderately disturbed children, has a much better prognosis when given specific help. The goal, in some cases, may be simply the relief of symptoms. Such approaches in this group will possibly result in the occurrence of other symptoms or the reoccurrence of problems at a later date. Where more intensive treatment is specifically directed toward the underlying causes rather than simply the relief of symptoms, there is a better chance of a more lasting benefit without a breakdown. However, even with recovery and the working out of the more basic causes of problems, no insurance can be provided against later breakdowns that might occur as a result of what the individual will meet as he continues to grow. (See *Childhood Emotional Disorders; Family Psychotherapy*)

***Are there programs of education for prevention of problems that cause children to become emotionally disturbed?***

There are many stirrings in this country in the direction of education for prevention of emotional problems. These seem to come from a number of sources—from lay groups using educational approaches, such as the mental health committees of parent-teacher associations, etc.; approaches through pamphlets, the use of mass media, and so on, by child-care groups and responsible governmental agencies such as the Children's Bureau and the National Institute of Mental Health; and through the development of school curricula to teach mental health principles and sex education appropriate for the age of the child. All these are extremely worthwhile approaches. They cannot, however, reach all the people who need the information or deal with all levels of problems that are encountered in the community, and they can appeal mainly to the intellectual understanding of problems and their prevention. True prevention will involve corrective approaches with mothers in the prenatal period, and with children early in infancy and childhood. This does not mean that early recognition of problems during the preschool, school, and adolescent periods cannot also lead to effective and significant corrective approaches that are preventive in nature. (See *Adolescence; Sex Education*)

*Has research in child psychiatry been responsible for any specific changes in the training and treatment of children?*

Child psychiatry has greatly influenced the concepts of child rearing. At times, however, there has been a misinterpretation of what psychiatric principles indicate should be included in the rearing of children. Permissiveness, in many areas, has been misinterpreted as a recommendation that came from psychiatry, which is quite the contrary to what psychiatric insights indicate. Learning cannot be all pleasure—there must be work, too.

*Based on current studies, what can be predicted about the methods and scope of child psychiatry in the near future?*

- 1) Prevention will be the keynote.
- 2) A reaching out to those who cannot come for help themselves will be instituted.
- 3) A wider use of associated relevant disciplines will be developed.
- 4) Treatment and care will increasingly move out of the institutions into the community. (See *Parenthood and Child Rearing; The Family in Illness and Health*)

# COMMUNICATION AND MENTAL HEALTH

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## *What is communication?*

Communication between animals, including man, is now generally believed to consist of any message or information passing between the members of a group of two or more. The many forms of communication, such as sign language, vocalizations (including speech), writing, painting, sculpture, dancing, rituals, telephone, radio, etc., will receive consideration in this article, but major emphasis will be on human language behavior as we see it in daily life.

## *How is "meaning" established in a message?*

Meaning of a message is inherent in the total context of the communication stream, including language behavior, paralinguistic, kinesic, and visceral components. It follows that the depth or scope of comprehension or understanding by a receiver depends upon his knowledge of the structuring of the stream of communication and the cultural subsystems relevant to the particular message in question. It is usually essential that the sender of messages receive a "feedback" (the return of some of the output to its original source) from the receiver in order to keep the stream of communication active and oriented to the topic.

## *What may be the extent of a message?*

Some messages may be of considerable extent in space and time, such as a war dance, a funeral service, or other rituals and ceremonials, and they may be more amorphous in size and shape than the customary messages of daily life, such as the handshake, or the tipping of a hat. They are symbols representing a thing, event, idea, mood, or attitude.

## *Is communication related to a specific culture?*

It is generally believed that the communication systems learned by persons in their infancy, childhood, and youth are indissolubly

related to other systems in the culture, the rudiments of which were acquired at the same time, such as eating, sleeping, manners, and religion. For example, a Chinese or Indian child learns the rules for his total behavior and not merely how to eat, walk, talk, or control his elimination; he learns how to be a coordinated man in the world of activities of China or India. Each culture develops ways in which the people who live together under this system can best survive a hostile environment and gain sufficient satisfactions to permit each individual to live in the system. This is the central reason why communication is an important topic in mental health.

***Is communication essential to life?***

Experiments with sensory deprivation and isolation, and a review of the accounts of polar explorers, solitary sailors, prisoners, and similar personal histories indicate that most people do not get along well without adequate human relations or appropriate sensory input, and may even become disoriented and experience hallucinations if deprived of them too long.

***What happens to some persons who are isolated too much?***

Persons who are separated too much or too long from human relationships may be said to be under pressure to become "dehumanized." Although some persons resist such pressures very well, others are quite susceptible to mental or emotional disturbances, as seen in prisons and concentration camps. Psychosis in some individuals may in large part be a state of isolation. Some scientists believe that the loosening of personal ties, as seen in modern urban living in an industrial society with relatively few and rather superficial family, church, and social group loyalties, is the cause of the lonely and purposeless state of modern man.

Human communication has been called "the fifth need," the others being air, water, food, and sex. In this sense it is biologically true that "Man does not live by bread alone." For many persons the need to be in touch with other human beings is a primitive need that cannot find adequate substitutes in such things as reading, music, objects, or animals. (See *Sensory Isolation*)

***How does communication affect mental health?***

All of us need some appropriate human relations although the extent may vary greatly. Most people need rather steady contact in order to feel "right," as is seen in many American housewives who need



to visit with other wives occasionally in order to avoid feeling lonely even though their children are with them during the day and their husbands come home at night. These human relations must contain proper components of reassurance, prestige, and respect, assuring the individual that he is in touch with reality, that he is not alone or likely to be abandoned, that survival is probable, and similar emotions, many of them too complex or amorphous to describe briefly; but every reader can amplify this analysis for himself.

If the incoming messages from human associations contain components of affection, love, admiration, hope, and the feeling that the person to whom they are directed is really needed or very important, the receiver is likely to feel much more alive and stimulated to activity. If the incoming messages are those of indifference, frustration, and discouragement, the receiver may reflect on this and be compelled to defend himself by drawing upon inner resources or by seeking aid from the environment, or by both.

#### ***How do hidden memories affect communication?***

The problem of appropriate communication becomes more complex when we remember that each person has a long, varied history of his own experience and that this becomes a part of himself. Not all of our past experience is easily remembered and some of it is deeply buried. This is especially true of childhood experiences and the more painful events that most people undergo while growing up. These "out-of-awareness" memories may often be dormant and then become more or less active although the person may not be clearly conscious of them. They may send messages to the central nervous system that may be disturbing. If such messages are sufficiently disruptive, we say that the person is sick with a mental or emotional disorder called *neurosis* or, in more severe states of disorder, *psychosis*. To be healthy, the human organism must maintain a balance between the internal and external messages so that the person can go about his daily tasks in an orderly manner as prescribed by the culture. (See *Memory; The Unconscious; Neuroses; Psychoses*)

#### ***How are communication problems related to mental illness?***

For lack of adequate experimental data it is not possible at this time to specify in what ways communication is related to or "causes" mental illness. Experts vary in their points of view and in their evaluation of the evidence that exists. There are many who believe that

mental illness is the result of physiochemical disorders that are relatively unaffected by environmental pressures. In an extreme form this view holds that the genetic constitution determines the life course and health of an individual, but most geneticists believe that environmental influences play some part in the growth and development of an organism both prenatally and postnatally through nutrition, metabolism, and other physical media.

At the other extreme, there are experts who believe that although genetic and physical factors are important in a growing number of identifiable diseases, most mental illness is a failure in adaptation to human relations and in this sense is due to a disorder of communication. Some writers on human communication claim that they need not take into theoretical account the presence of intrapsychic conflict although their practical examples usually show these to be present. Most psychiatrists and psychologists take a middle position and try to study all physical, biological, psychological, and social factors that are available to them. Psychiatry has been defined as a study of the disorders of thinking, feeling, and acting, and as such is basically concerned with the disorders of communication between people. Clinicians, in a survey of the disordered behavior of a patient, e.g., his signs and symptoms, try to evaluate and synthesize this data in a unified clinical syndrome or picture of the symptoms. The next task is to identify as accurately as possible those factors that seem to be causing the disorder and to deal with each one as intelligently as possible. It is relatively easy to identify and deal with some of the concrete aspects of alcoholism, diabetes, peptic ulcer, melitis (inflammation of the cheek), or obesity, but it may be much more difficult to know why a person will not stop drinking or follow medical advice regarding drugs and diet that would help him to regain health. If a patient is suffering from psychomotor epilepsy or the residuals of a head injury it may be clear what physical treatment is best for him, but he must also be willing to live in ways that will keep his symptoms to a minimum. In disorders such as hysteria, the obsessions, and phobias, or some of the schizophrenias, it is not yet clear to what extent disordered communication in childhood and later life is responsible for either the symptom-picture or the underlying disorder, if in fact there is one independent of human relations. Current research is broadening our insight and our perspectives into the multiple factors that may disrupt the harmony between a husband and wife, parents and children, workers and management, psychotherapist and patient. Communication is often dis-

ordered in these relations, but we are not yet able to be sure that this is a primary factor in most disorders.

***Is communication important to infants and children?***

Appropriate communication is also vital to a person during the formative stages of becoming human during infancy and childhood. The ways in which the parents and other members of the family treat the child is determined by the culture and the susceptibility to mental or emotional disorder, which is closely related to the culture. This does not negate the vulnerability to mental disorder that may be present due to genetic heritage. The infant is particularly vulnerable to incoming stimuli because he does not yet possess the mental apparatus to handle them. The ability to sort out incoming sensations must be developed over many months, and although reasonable mastery is attained by the fifth or sixth year, some persons do not really gain good control until their twenty-first year or later. Gregory Bateson believes that all of us must learn what to learn, what not to see, hear, and learn, and also "how to learn to learn." (See *Child Development*)

***What disciplines are interested in the study of communication?***

In one sense every science is concerned with the methods developed for dealing with its own concepts and data and how to relate them to the world. There are a number of disciplines that are primarily concerned with communication and most of them fall more or less within one of two groups, namely the traditional disciplines concerned with human language behavior, now augmented by studies of animal communication, and the new disciplines that are centered under the names of information theory or cybernetics.

***What is language?***

Language is defined in two ways by expert linguists. Language as broadly conceived is approximately the same as communication has been defined in this article. Language is narrowly defined as "an arbitrary system of vocal symbols by means of which human beings, as members of a social group and participants in a culture, interact and communicate." (George L. Trager)

***What is the relation of speech to written language?***

Linguists agree that spoken language is primary to written language, in spite of the mistaken ideas that grew up after writing was

invented some time after 8000 B.C. "Writing" is the use of symbols to represent other symbols. The strong belief in the written or printed word as a relatively fixed independent entity rather than as a symbol that represents things or ideas (and is not the thing it represents), is the cause of considerable misunderstanding. The issues are often complex and are by no means settled. Over many centuries experts with differing axioms and methods have introduced a large number of questions that will require much more experimental data and new concepts for their resolution.

***What are the traditional disciplines concerned with language behavior?***

Professionals who are directly concerned with language behavior are linguists (often with a background of cultural anthropology), anthropologists, experimental, comparative, developmental, and social psychologists, phoneticians, philologists, grammarians, etymologists, semanticists, semeiologists, logicians, and philosophers. Psychiatrists have always been interested in communication because of their basic concern with human behavior however deviant, and with human relations. More recently ethologists, psychoacousticians, and many social scientists of varied background have developed new concepts and tools and are adding to our knowledge.

***What are the means of human communication?***

Human messages may be thought of as being sent out through four different media or channels, each of which may be said to be composed of subsystems.

- A. Lexical systems
- B. Paralanguage systems
- C. Kinesic systems
- D. Visceral systems

A. The *lexical system* is composed of such messages as can be relatively easily coded and written, including words as they appear in the dictionary, and logical, mathematical, musical, physical, chemical, and other technical symbols.

B. *Paralanguage*, according to George L. Trager, consists of vocalizations and voice qualities. These are qualities of speech or talking that appear in a background of voice sets, which is a matrix of the idiosyncratic properties of the speakers, their specific physiology, and the

total physical setting, and is defined by Trager to be in the area of pre-linguistics. "Voice set," Trager says, "involves the physiological and physical peculiarities resulting in the patterned identification of individuals as members of a societal group and as persons of a certain sex, age, state of health, body build, rhythm state, position in a group, mood, bodily condition, and location. From the physical and physiological characteristics listed are derived cultural identifications of gender, age grade, health image, body image, rhythmic image, status, mode, condition, locale—and undoubtedly others." Paralanguage is also defined as a part of metalinguistic activity, which consists of studying relations between language and any of the other cultural systems.

Voice qualities are those properties of speech identified as pitch range, vocal lip control, glottis control, pitch control, articulation control, rhythm control, resonance, and tempo. Vocalizations are specifiable sounds described in terms of (1) vocal characterizers such as laughing, crying, yelling, whispering, moaning, groaning, whining, belching, yawning, and others; (2) vocal qualifiers defined in categories of intensity, pitch height, and extent; (3) vocal segregates (Bateson) consisting of such "saudids" as uh (hesitation), sh, uh-uh (negation), uh-huh (affirmation), coughs, snorts, sniffs, and imitations of animal cries. There are many refinements possible within the categories mentioned, but most elements of human speech can be described in less than fifty of them.

C. *Kinesics* is defined by R. L. Birdwhistell as "the systematic study of the communicational aspects of body motion." Much of this is learned early and out of awareness as a part of an individual's training to be a member of a group. Although body motion studies reveal to date no subdivisions exactly analogous to the formal divisions of language, it is possible to record human body motions from movies, in about fifty categories that will permit correlations between them and the lexical and paralanguage components.

The assumptions of kinesics are those of linguistics as developed by Edward Sapir, George Trager, L. H. Smith, Gregory Bateson, and Charles F. Hockett. And Bateson says, "Everything which occurs in a social interaction is meaningful in the sense of being part of the interchange as well as nonaccidental," and "Nothing never happens."

Although, according to Birdwhistell, "body motion behavior is based in the physiological structure, the communicative aspects of this behavior are patterned by social and cultural experience." It is impossible at this time because of lack of data both in our own subculture

and comparative studies to say what the relations of the lexical, paralinguistic, and kinesic systems are in different groups or contexts. Only direct observation of large samples and cross-cultural comparisons will permit generalizations about the prepotency of a system in various settings. The eyes, mouth, face, or hands may be cited by informants as carriers of a primary meaning, while other systems are cited as being modifiers, but this does not always bear up under analysis. Nor does simple counting of an action such as an eyewink or toe-tap usually give significant information about the communication pattern. To be significant such actions must be seen in context.

D. Although relatively little experimental work has been done on *visceral systems*, they are of sufficient importance to be given special mention as the source of messages distinct from the categories described by Trager in his discussion of voice set. It is a matter of common experience that the information contained in red-faced but silent rage, blushing, blanching, or tight-lipped muscle contractions may be powerful. The throbbing of the temporal or carotid arteries in the head and neck, the increased respiratory rate, contraction and dilatation of the pupils, pilomotor erection of the hair, are also signals that alert us even when they are not in conscious awareness. Wet or dry palms, the amount of body perspiration or oil in the hair, body odors, borborygmi (noises in the intestines), and other body noises may also be significant signals in the stream of communication. Some persons are particularly acute in detecting these signals either in or out of awareness, and are thus able to deal much more skillfully with the persons concerned. The experiments of Milton Greenblatt and his co-workers, and of R. B. Malmo, showing the visceral correlations between a patient and his therapist, illustrate the potential use of these studies.

The animal experiments of J. V. Brady on the "executive" monkey and of Robert Earle Miller on the empathy between monkeys, furnish much new material for studying these levels of communication, which have been neglected. They show that the communication of affects (emotions) in monkeys may be apparent and recordable even under the limiting conditions of an experiment.

For students of human communication it is particularly interesting that many messages about the state of the person and his attitudes and beliefs may be revealed at levels other than those at which messages are put into words (the lexical), namely, at the levels of paralanguage, kinesics, or visceral activity. While the two latter media are relatively

limited in scope, they may transmit important messages when they do become prominent in the communication stream. The messages from any two or three of these levels may be congruent or out of phase or even contradictory. Such contradictory or out-of-phase messages are of particular interest to the experimental psychologist and psychiatrist because there is good reason to believe that these messages are pathogenic in dealings between adults, but perhaps more so in the relations between parental figures and a child.

### *What is "information theory"?*

Information theory, according to R. P. Mackay, is "concerned with the making of representations, i.e., symbolism in its most general sense." Information is defined as "that which alters representations." Messages may be isolated and identified as having the form of signals or signs. Signals (an utterance, a transmission, a written, spoken, gestured sign) are defined as "the physical embodiments of a message," whereas a sign is defined by C. Cherry as "a transmission or construct by which one organism affects the behavior or state of another in a communication situation."

Although this subject was treated in a tentative way by several authors in the 1920's, it was given a definite entity by C. E. Shannon in 1948. It is primarily based in engineering problems of communication over systems, such as the telephone or radio, that can be treated mathematically. It has also aroused the interest of neurophysiologists who hope to understand better the working of the human central nervous system by similar means. Information theory is interested in such problems as feedback, noise, capacity, redundancy, rate of transmission, information input and overload, coding of messages and errors, and ultrastability (William R. Ashby; C. Cherry). These statistical theories of communication are extremely valuable in systems other than human speech, up to the present, but their relative usefulness to human language behavior must be demonstrated at various levels before we can be sure where they will be most helpful.

### *How does human language behavior differ from a telephone system?*

Human communication in daily life may appear at times to have a discrete, atomistic, logical, or digital character, but usually the stream of communication is continuous, gestalt-like, and analogic in nature. The fact that many "pieces" of behavior, excepting the technical languages of mathematics, logic, and the sciences, seem to be discrete de-

pend upon the arbitrary choice of the observer. It is often useful to single out such "pieces" of behavior as walking, talking, eating a dinner, lighting a cigarette, laughing, and crying, and treat them as well-defined events whose limits can be described. However, in more searching examinations it is usually desirable or necessary to consider the total context of the stream of communication insofar as feasible, including the system set up by the sender-receiver on one end of the system and his counterpart on the other end. It is essential for full understanding to keep in mind that such a two-person system does not operate in a sociopsychological vacuum, but is embedded in a particular subculture, and that each individual has idiosyncratic characteristics derived from his genetic heritage and his long history of acquired experience.

Communication becomes possible insofar as sender and receiver "understand" each other, i.e., share the common background that enables them to perceive and translate the signs and signals being transmitted and to respond at similar levels or in ways that are acceptable or intelligible to the receiver. A mother communicates constantly with her children and husband, adapting the messages so that they will be appropriate to the capacities of the person addressed, the subject in question, and the circumstances that surround the message. Similar processes are visible in a governor speaking to a legislature or to a political meeting, or in a teacher speaking to different pupils. The speaker and the listener must have a common frame of reference (ideas, postulates, attitudes, schemata), even when using the same language, in order to be intelligible to each other. This is particularly evident between children of different age groups who do not share the same ideas (J. Piaget), or between strangers attempting to use an unfamiliar tongue, professionals of different occupations, or persons of different social classes.

This high specificity for most human communication derives from the fact that such communication is overwhelming learned behavior in a cultural context that has many concomitants. While a child is learning the basic rhythms and intonation patterns of his first language, he is also learning to eat, walk, dress, and exercise many other forms of control of himself and the environment.

### ***What is cybernetics?***

Cybernetics is the term proposed by Norbert Wiener to cover much of the same area as information theory, but it also includes much material from neurophysiology, symbolic logic, systems analysis, ex-



perimental psychology, and psychiatry. It is defined as "the science of control." It brings a more mathematical attitude to the study of the regulation of biological systems.

***Who are the "linguistic philosophers"?***

This is a term sometimes applied to a set of philosophical views about the nature and functions of language proposed originally by G. E. Moore, Bertrand Russell, and Ludwig Wittgenstein. More recently these views are associated with the writings of J. L. Austin, G. Ryle, and P. F. Strawson, who are also known as members of "The Oxford School." John O. Wisdom is of particular interest inasmuch as he has been called the most distinguished pupil of Wittgenstein and has written a book entitled *Philosophy and Psychoanalysis*. These writers apparently believe that many philosophical problems arise from the misunderstandings in the use of words and from bad grammar. This does not mean that they favor the views of linguists who have adopted anthropological views such as those of George L. Trager that are reproduced here.

Perhaps it is fair to say that modern linguists realize even more than the linguistic philosophers how relativistic and culture-bound all human messages tend to be, and that in order to fully understand them it is essential to have much data about the total context of the stream of communication in which the messages are embedded.

***What is dianetics?***

This term was introduced by L. Ron. Hubbard in 1950 as a "modern science of mental health," but did not gain much acceptance.

***What is semantics and can it be used for therapy?***

Webster defines semantics as "the science of meanings, as contrasted with phonetics, the science of sounds." In the 1930's, Alfred Korzybski developed a theory of mental health depending upon the proper use of words and concepts. Korzybski's major work is called *Science and Sanity: An Introduction to Non-Aristotelian Systems and General Semantics*. His pupil, S. I. Hayakawa, continued this work.

***Are ideas and the words that represent them the primary messages?***

Older descriptions of communication functions stressed the transmission of "ideas" as primary, but it is now recognized that much of

human communication involves transmission of messages regarding states of being or emotions. They may be relatively well-defined at any given moment but may also be highly diffuse and therefore not easily coded. The fact that such states are well-defined in form or content does not mean that transmission of data reports about them may not be very important since such reports may be, and often are, vital to the integrity of a person in maintaining his orientation to his social world.

The crucial need for continuous sensory input of appropriate content, quality, and quantity has been dramatically demonstrated in the so-called sensory deprivation or isolation experiments of Donald O. Hebb and of J. C. Lilly. The human being must have proper sensory input, avoiding deprivation or overload in order to maintain his adaptation. He must learn how to do this both by "learning to learn" and by learning what to avoid, suppress, and repress ("learning not to learn"). (As pointed out by Sigmund Freud, repression is the price of civilization.) The analogy between these functions and the sensory activities of the neurophysiologic model of the central nervous system is obvious. We must learn what to obtund (reduce the edge of) or avoid of the sensory data available to us every second or we could not attend to that which concerns us most at the moment. These background messages are also vital in the communication involved in works of art such as poetry, music, or painting, where feeling-tones are central components to the intended messages.

Weston La Barre proposed the name "phatic communication" (pseudolanguage) for this type of message and its usefulness is readily apparent in many daily examples. When we say "Good morning!" or "How do you do?" to each other, we are seldom making a literal inquiry, but rather are signaling states of being to others, and we expect them to reciprocate so that we may know how to proceed with whatever business is before us.

In addition to more or less explicit messages that can be coded and those concerned with "phatic communication," there are also messages about the communication process itself.

For this new order of communication, the term "metacommunication" is here introduced and defined as "communication about communication." We shall describe as "metacommunication" all exchanged cues and propositions about (a) codification and (b) relationship between the communicators. We shall assume that a majority of propositions about codification are also implicit or explicit propositions about rela-

tionship and vice versa, so that no sharp line can be drawn between these two sorts of metacommunication. (Jurgen Ruesch and Gregory Bateson in *Communication, the Social Matrix of Psychiatry*)

Charles F. Hockett broadens this concept into that of "‘immanent reference’; no matter what else human beings may be communicating about, or may think they are communicating about, they are always communicating about themselves, about one another, and about the immediate context of the communications." (Robert E. Pittenger *et al.*, in *The First Five Minutes*)

Many of these messages together with the accumulated repository of a person's previous experience, including his genetic heritage, are often, and usually predominantly, not in the field of awareness, i.e., in the conscious, and are therefore not easily accessible for explicit coding. It is a commonplace since the dissemination of Freud's ideas about the unconscious functions, that most of our thinking is not in the field of awareness, but that much of the repressed material may be recovered if sufficient effort is made to do so.

***Why is a highly detailed study of human communication using movie film and sound tape desirable or even necessary?***

Although men have known for centuries that human communication in all its richness is composed of much more than words that can be written, it has not been until recent times that linguists and others have developed more adequate means of analyzing and describing by means of written symbols many of the properties that characterize human communication. Everyone is conscious of the fact that it is not merely the words that are used, but the "tone of voice" or the "manner" in which a person speaks that gives full import to his message. Because the history of a science is often "a history of its techniques," it seems probable that the use of the improved tape recorder, movie camera, and time-motion analyzer provided the means by which experts were able to produce new data that could be studied repeatedly by several observers and compared with other samples. This new data made possible much better close-grained analysis of behavior, which was generally unavailable although its importance had been recognized earlier by some experimentalists and by such psychoanalysts as Freud in *The Psychopathology of Everyday Life*, Sandor Ferenczi, Theodor Reik, Georg Groddeck, Trygve Braatøy, Sandor Feldman, Frieda Fromm-Reichman, and Harry Stack Sullivan.

From the scientific point of view it appears that these new concepts

and the data obtained by the new techniques will open up entirely new vistas in the study of communication and language behavior. While the ultimate value of microlinguistic-kinesic analyses and the digital computer for processing this data cannot even be guessed at currently, it seems very likely that the problems in the patient-doctor relationship and the therapeutic process that leave so much to be desired will now be much more available for study because of the new concepts and data. Furthermore, the canons of science will be better served in that the data can be reviewed an indefinite number of times by many observers from many disciplines, each with his own hypotheses. It is apparent that even though the movie and tape are definitely not the equivalent of directly seeing two human beings interact, they do provide much more substantial data than anything available heretofore, and only technical skill is required to avoid the pitfalls created by the artificial media.

***How has modern technology made possible some of these new developments?***

The ready availability of high quality movies and sound tape, slow motion analyzers, television (video tape), oscillographs, and other instruments has given considerable impetus to the study of human communication and this will undoubtedly continue to flourish. Since many units of communication behavior can be defined for practical purposes in mathematical terms, even though the stream of communication is continuous and therefore analogic rather than digital, the prospects for using digital computers for some areas of investigation seem excellent. This will be of tremendous importance in handling the relatively large number of different units that must be considered in a microanalysis of a piece of human interaction of even five minutes duration.

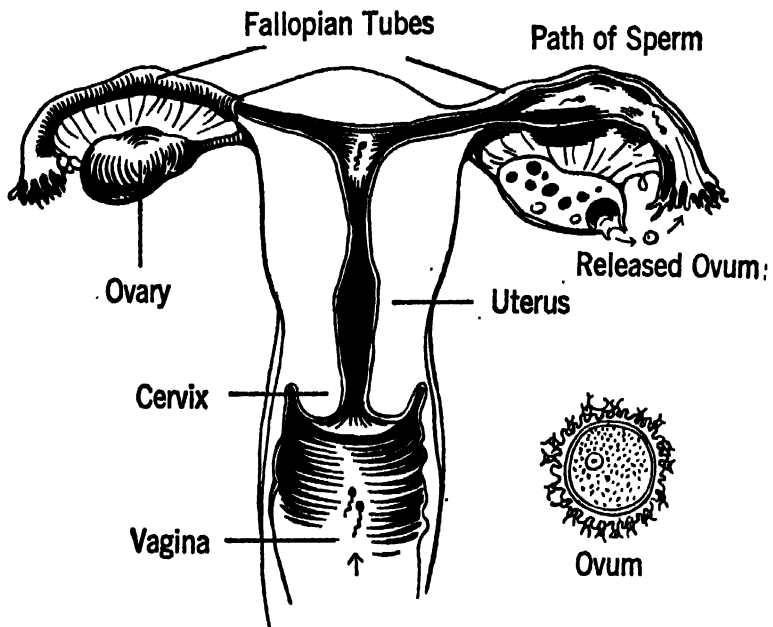
***Of what value are the studies of animal communication to the study of human systems?***

Recent studies in animal communication systems have greatly increased our perspective about these systems in general and human systems in particular. It now seems probable that the predecessors of Homo sapiens had integrated communication systems that were essential to living and hunting in groups, and that the toolmaking activities as contrasted with mere tool using were an important stimulus to the development of the cerebral cortex and more complex language be-

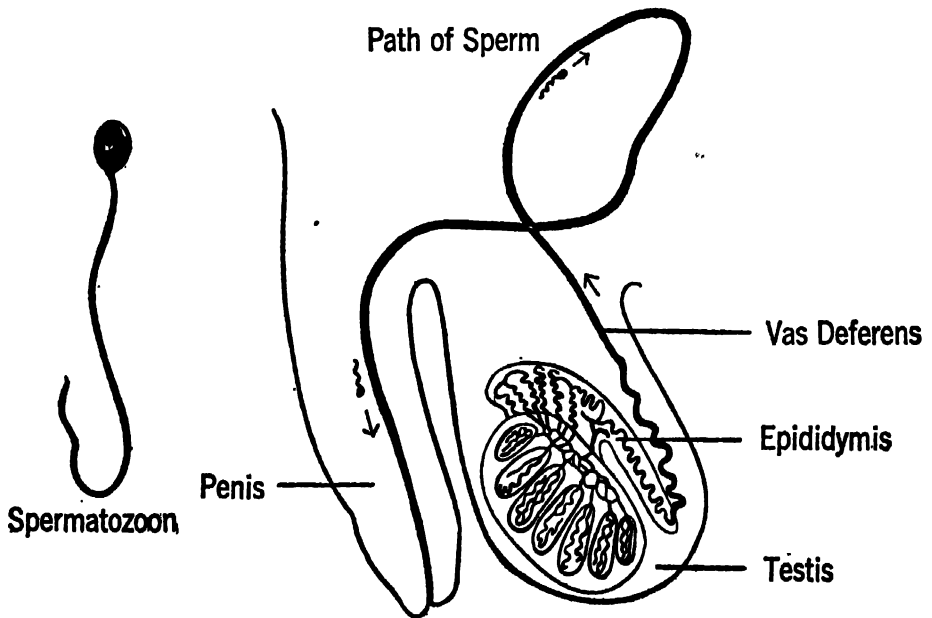
havior. Because data are scarce for more remote periods, scientists can only speculate about the early phases, but these are fascinating in their implications and undoubtedly will attract more attention as new data are available.

*From existing evidence, what are the prospects for improved human language behavior and the fostering of mental health?*

From existing data it now seems certain that communication systems, including all language behavior, are an evolutionary development concomitant with other cultural systems that make it possible for man to survive in a hostile environment by living in organized groups or cultures. There is a biological basis for all systems that operate in a culture, such as food-getting, courtship, and rearing of the young, and this includes the language behavior, which is an essential activity in the life of a group. Man's highest achievements in art, literature, and science are outgrowths of the basic cultural activities. The steady progress from early beginnings twenty to forty thousand years ago can now be traced with greater assurance. There is no reason to assume that man cannot achieve much higher levels of cultivation if he does not destroy himself.



FEMALE REPRODUCTIVE SYSTEM



MALE REPRODUCTIVE SYSTEM

# CONCEPTION, PREGNANCY, AND CHILDBIRTH

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## ***How does natural conception occur?***

It occurs by the union of a sperm cell and an ovum inside the woman's reproductive tract and by the implantation of the product (of that union) in the wall of the uterus.

## ***Prior to and during intercourse, what are the most favorable physical and emotional conditions for conception?***

The physical health of the sexual partners should be generally good, although conception can occur even in the presence of severe illness such as diabetes, heart disease, or tuberculosis. The reproductive organs should be free from disease or structural abnormality. The man should be sexually potent and in love with his wife; the woman should be in love with her husband, eager for intercourse and pregnancy, and relaxed and self-confident about her femininity. (See *Sexual Relations and Marriage*)

## ***Do exterior physical conditions such as time of the year, temperature, or climate have any effect on conception?***

Apart from the influence of these factors on sexual desire or opportunities for sexual intercourse there is no evidence that they affect conception.

## ***What is the age range during which conception can occur?***

From puberty through the menopause—usually from twelve years of age to the mid or late forties. Instances of conception in children as young as six to eight years of age are occasionally reported. Conception in women above the age of forty-eight is rare. (See *Menarche; Menopause*)

## ***What is the age range in which a male can impregnate a female?***

From puberty until extreme old age. (See *Adolescence; Impotence*)

***At what time of the woman's sexual cycle is conception most likely to occur?***

In many women, conception is most likely to occur at the midpoint of the cycle—about fourteen days before the onset of the next expected menstrual period. It is possible for conception to occur at any stage of the cycle.

***What is the relation between time of the cycle and body temperature?***

The basal morning temperature—the woman's temperature immediately after awakening in the morning—rises one to two degrees Fahrenheit the day following the ovum's descent into the Fallopian tube. The temperature remains elevated until conception or the onset of menstruation. (See *Menstruation and the Sexual Cycle*)

***Is it possible for a woman to conceive before menarche, during her menstrual period, or during or following her menopause?***

A woman can conceive after the onset of ovulation. Conception is possible fourteen days before the onset of the first menstrual period, if ovulation occurs. However, some girls do not ovulate preceding their first menstruation. Conception has occurred during a menstrual period, probably due to a new ovum being extruded in response to the stimulation of sexual intercourse. Ovulation continues sporadically during the menopause; hence conception is possible. After the termination of the menopause, ovulation stops and conception can no longer take place.

***For what physical reasons might conception not occur? For what emotional reasons?***

Because of physical illness or structural abnormality of the reproductive system of either partner, or because intercourse is occurring at the wrong times in the cycle of the particular woman. Women with deep-seated conflicts concerning their femininity and ambivalence about becoming pregnant may show a psychosomatic response in which ovulation is inhibited, even though menstruation occurs. Such women may also suffer from functional disorders of their reproductive tracts, so that although they may ovulate and the ovum may be fertilized, there may be no implantation of the product in the wall of the uterus. Impotence in the man due to conflicts over his masculinity, or unconscious fears of women, will prevent impregnation. A similar result will occur if the woman's sexual conflicts and rejection of her



mate express themselves by a muscular spasm that closes the opening of her vagina and mechanically prevents intercourse. (See *Frigidity*)

***Why do some women conceive for the first time after adopting a child?***

Because adoption symbolizes acceptance of the inability to conceive, so that a conflict between wish for a child and fear of becoming pregnant, which previously led to inhibition of ovulation or interference with implantation of the fertilized ovum, is now resolved. Once the unconscious psychological defenses are laid aside, the woman's sexual apparatus returns to a normal state. Another factor that is sometimes significant is that taking care of a baby stimulates growth in a woman's maternal feelings, and this breaks the deadlock in her conflicts and weighs the balance down in favor of her feminine impulses. (See *Adoption*)

***What treatments are available for couples who are not able to conceive for physical reasons? For emotional reasons?***

Treatments for the woman who has some structural abnormality or disease of her reproductive system cover the whole range of gynecology. Some clinics specialize in investigating and treating the causes of sterility, not only in the woman but also in the man, whose production of fertile sperm may have to be stimulated by appropriate medication.

Emotional causes of sterility may also be treated in these clinics by psychotherapy for either or both partners, or the couple may be referred to a psychiatrist elsewhere for psychotherapy or psychoanalysis. Occasionally tranquilizing drugs may serve to lower the intensity of unconscious conflicts sufficiently to stop the inhibition of ovulation or implantation.

***How successful are these treatments?***

This depends on the causes of the sterility. Minor physical or emotional disorders can be rather easily relieved. Clear-cut physical conditions, even those of major proportions, yield to modern medical and surgical treatment. Psychoanalysis is often successful even in long-standing and deep-seated psychological disorders. The outlook, however, is not so good in those cases where no clear abnormality is found in the woman, or where the trouble is traced to an insufficient number of fertile sperm cells in the man. (See *Sterility*)

***What are test-tube babies?***

This term is sometimes used as synonymous with artificial insemination. Some people use the term for the process that was fantasied by Aldous Huxley in his work of science fiction, *Brave New World*—namely, the fertilization of an ovum outside the human body and the nurturing of the embryo and fetus in an artificial culture medium—literally in a test tube. Research workers have recently demonstrated that fertilization of a human ovum can take place in appropriate tissue culture fluids in a test tube, and that the embryo can be kept alive during its first few cell divisions; but there is no indication that this process can be kept going for any appreciable length of time.

***What is artificial insemination?***

Artificial insemination involves the mechanical implantation in the woman's reproductive tract of fertile sperm drawn from her husband, or from some other male, or a combination of sperm from husband and donor. It might be used if the husband is impotent, that is, if he produces fertile sperm cells but is not able to deliver them adequately in intercourse, e.g., if he is physically crippled or suffers from muscular paralysis or psychologically determined impotence. If the husband is sterile, sperm can be obtained from a fertile donor and be used to fertilize the wife. Artificial insemination of donor semen is not often used, mainly because of ethical and psychological objections. These objections do not apply to artificial insemination of the husband's sperm, which is not a common procedure simply because the underlying causes are rare. Undesirable effects of the use of sperm from an unknown male are due to feelings in both husband and wife that an alien influence has invaded their marital relationship—as in fact it has. It is not uncommon for both partners to feel that the child resulting from such insemination is an obvious symbol of the failure of their union. The wife has fantasies of guilt because of her medically sanctioned "adultery," and may begin to fantasy a "potent lover" where potency and ability to impregnate are equated; and the husband may feel that she has somehow been unfaithful to him and that he has failed her.

***What kind of individual is chosen to be the "artificial father"? Does he have any emotions about his role?***

Donors are usually chosen from healthy young men of mature personality who have a good family background as regards freedom from

hereditary defects. There is no indication that they are emotionally affected by the role, apart from some curiosity, which cannot be satisfied, regarding the outcome of their service.

***What effect could knowledge of parenthood by artificial insemination have on the child?***

It might stimulate fantasies about the unknown father and distort the relationship with the mother's husband. In the case of a boy this in turn might interfere with his identification with his fostering father and with his feelings of confidence in his own masculine identity.

***Might artificial insemination be used more frequently in the future? What might be the total effect of artificial insemination on the mental health of the world?***

Recent technological advances enable sperm to be stored for indefinite periods without loss of potency. It is also within the bounds of possibility to use not only donor sperm but also donor ova, which may be implanted, fertilized or unfertilized, in a woman's uterus—a similar feat has already been accomplished in cattle. These processes will give man, for the first time, the power to breed people with the same eugenic control he has achieved in breeding animals. Thus not only may it be possible for persons with poor genetic backgrounds to have healthy children, but the sperm of men with outstanding physical and mental capacities might be stored for years, and used repeatedly to "father" large numbers of potentially outstanding children. Such developments might lead to a greater use of artificial insemination with awesome possibilities for benefit to humanity. They might also lead to great dangers if unscrupulous rulers were to use the techniques to breed races of slaves or human robots. We have little evidence upon which to base the confidence that when man achieves control over his own genetic destiny he will use it for good and not for evil, and that the mental health of the world will necessarily be improved. On the other hand, as with atomic power, a tremendous potential for benefit will accrue if our morality can catch up with our technological progress.

***How does pregnancy affect the relationship between the husband and wife?***

Pregnancy, and especially the first pregnancy, complicates the relationship between husband and wife. They are stimulated to plan jointly for the coming baby and for their future roles as parents. On

the other hand, psychological changes in the expectant mother interfere with her previous relationship with her husband, and the close link between the partners begins to open up to include the baby—at first purely in fantasy, and later in actuality. These changes have a maturing effect on both husband and wife, as individuals and as a couple. At the beginning of pregnancy the partners achieve a greater intimacy and a feeling that their love for each other has been concretely consummated. Later on they progress to the even higher stage of satisfaction of their needs for generativity, as they envisage their joint responsibility for bringing new life into the world. Pregnancy can be a rewarding experience if the marital partners support each other in facing these developments and the psychological challenges of their more complicated individual and joint roles. (See *Parenthood and Child Rearing*)

***Are psychological changes common in pregnant women? Do these changes manifest any characteristic pattern?***

Most women show psychological changes during the period of pregnancy. The details of the changes will vary with a woman's enduring personality traits, but certain general changes are found sufficiently often to constitute a characteristic pattern.

The psychological manifestations seem to vary in appearance and in intensity according to the phases of the pregnancy period, just as do the physical and chemical changes.

***What causes the psychological changes?***

We are not certain, but we believe they are influenced both by the biochemical changes, especially the complicated alterations in hormones (the secretions of the ductless glands) and by the psychological reactions to pregnancy—the preparation for the coming baby and for the assumption of the maternal role.

***What are the common emotional manifestations of pregnancy? Is the pregnant woman subject to mood swings?***

It is usual for the prevailing mood of the woman to change during pregnancy. Some women feel better during pregnancy than at any other time. Others feel unusually depressed throughout pregnancy. Sudden unexplainable mood swings are not uncommon, even in women who usually are emotionally stable. Many women have short periods of depression—the so-called blues of pregnancy.

***Are the mood changes a reaction to some ascertainable cause?***

Probably not. They are not, for instance, related to whether the woman wanted to become pregnant or not. A woman who very much wanted a baby may be depressed, and a woman for whom pregnancy is an unwelcome burden may feel elated. The surprising and inexplicable nature of these changes is quite frightening to some women, who fear that these symptoms are signs or precursors of a mental illness. As a matter of fact, such mood changes are found in normal women and probably have no relation to mental illness.

***Do pregnant women show changes in emotional sensitivity and irritability?***

Yes. Common changes during pregnancy include a tendency to become angry at slight provocation, to laugh and cry easily, and to have rapid fluctuations in mood as a result of minor external stimulation.

***Is it possible for the mother's emotional state to have beneficial or harmful effects on the unborn child?***

The expectant mother's emotional state may affect her appetite and eating habits, so that she may overeat and develop toxemia with consequent danger to the fetus, or she may eat a diet deficient in essential food elements and so damage the baby. There is also some evidence that a woman who is extremely anxious or depressed during pregnancy is likely to give birth to an irritable baby who has an increased chance of suffering from colic. It is difficult, however, to be certain whether the latter effect is due to the influence of the mother during pregnancy, or whether the baby's irritability is not entirely due to the tensions with which she handles him after birth.

***Is there increased sensitivity of the special senses?***

Yes, especially of the sense of taste and of smell. Pregnant women have an increased tendency to disgust in response to stimulation of these senses. Nausea and vomiting are common in the first few months.

***Do changes in appetite occur?***

Food fads and cravings for unusual food and drink are common in pregnancy, as is also a generally increased appetite, which may lead to difficulties because of the dangers of weight increase in this period.

Increased appetite during pregnancy is a physical manifestation of

the woman's emotional introversion and need to receive increased supplies in order to prepare herself to give of her own substance to her baby. Food fads are sometimes due to a primitive awareness of a lack of some essential food constituent in the diet—for instance, the development of the fetus leads to an increased need for calcium, and if this is not present in sufficient quantity in the diet, the expectant mother may develop a craving for egg shells, chalk, or plaster off the walls, all of which contain calcium.

***Does the mother's diet and use of alcohol have an effect on the unborn child?***

Yes. The diet should optimally contain increased amounts of protein, vitamins, and mineral salts—especially calcium—in order to feed the developing fetus. If the diet is deficient, the baby may be mal-developed or may be born prematurely, with consequent danger to its physical and mental health. Excessive intake of alcohol interferes with adequate nutrition of the mother and hence of the fetus.

***Does smoking and use of drugs have an effect on the unborn child?***

The effect of smoking is not known. The effect of drugs is similar to that of alcohol. Insofar as addiction interferes with the mother's general state of health, it may harm the fetus. On the other hand, the fetus is protected to a high degree from the direct effect of drugs ingested by the mother.

***Do changes in sexual desire and performance occur?***

Such changes occur in many women at varying phases of pregnancy. A diminution of sexual desire is common toward the middle of pregnancy. Some women have increased desire, and it is not uncommon to find women who experience orgasm only during pregnancy.

These changes, as we have noted before, may possibly be due to complicated changes in the pregnant woman's hormones. They are more likely, however, to be due to psychological factors. Sexual desire in the wife may previously have been impaired by fear of pregnancy, which is now removed, or by her feelings of doubt about her femininity, which are now reduced because conception has proved that she is fertile. In some cultures women proudly exhibit the external signs of their pregnancies, and men regard these as signs of beauty. In these cultures the woman's awareness of the physical changes of pregnancy

may stimulate her sexual desire. In other cultures women feel less beautiful during pregnancy, and sexual desire may therefore be inhibited by feelings of shame or modesty, or by the fear that their husbands will turn away from them. Sexual desire and performance may also be inhibited by the unfounded fear that intercourse will harm the fetus by pressure on the abdomen or by trauma to the uterus.

*Do pregnant women tend to be introverted and passive?*

Introversion and passivity are the chief characteristic emotional changes of pregnancy. These changes usually begin during the second or third month and gradually increase in intensity reaching a peak around the seventh or eighth month. The woman, who previously may have been an active outgoing person, and whose role as wife and mother has been one of nurturance and giving, gradually or suddenly becomes turned in on herself, feels passive and lazy, and wants to be cared for instead of caring for others. She has increased needs for demonstrations of love and affection.

These changes often continue for about two to four weeks after childbirth.

*Is there any change in the pregnant woman's control of irrational thoughts and fantasies?*

One of the most interesting psychological changes found in many pregnant women is that irrational thoughts and fantasies, which usually are kept out of consciousness, are allowed to come to the forefront of thinking. This is accompanied by the revival of childhood memories, previously repressed, of old conflicts regarding sexual matters, such as masturbation, and regarding complicated relationships with others, especially parents, brothers, and sisters.

This process usually begins in the second or third month, reaches a peak about the seventh month, and does not revert to normal until about three or four weeks after delivery. Following this the woman rapidly forgets what has happened, as the memories and fantasies are once more repressed out of consciousness.

*Is there a resemblance between this process and some of the manifestations of psychosis?*

The invasion of rational conscious thinking by irrational thoughts resembles in certain respects what is found in schizophrenia. Per-

sonality tests, such as the Rorschach, show a similar picture in pregnancy and schizophrenia. The difference is that a pregnant woman knows the fantasies are unreal, whereas the psychotic woman usually finds it difficult, or is unable, to differentiate fantasy from objective reality.

***Is the reappearance of old fantasies and conflicts accompanied by anxiety?***

The pregnant woman is much less anxious about the revived memories, e.g., of her old guilty or shameful thoughts about adolescent masturbation, or of childhood jealousies and vengeful thoughts about a brother or sister, than would probably be the case if the same thoughts occurred to her when she was not pregnant. On the other hand, as pregnancy proceeds, and as more of such irrational thoughts appear in consciousness, many pregnant women show an increasing generalized anxiety, which does not focus on these particular thoughts and memories, but seems "free-floating." In many cases the anxiety is displaced and focuses onto situations and events in a phobic manner, e.g., the woman develops an irrational fear that she will die in childbirth, or that she will give birth to a monster, or that if she sees a mouse her baby will be deformed, or that if her craving for grapes is not satisfied the baby will have a grapelike birthmark, etc. Many of the themes of these phobias seem like symbolic self-punishments that may be unconsciously linked with guilt associated with the old conflicts. ~

***Does the reappearance of these old conflicts affect the future mental health of the woman or her relationship with her baby?***

The spontaneous revival of old conflicts provides the woman with an opportunity for working out a new solution for those that were unsolved or precariously solved in the past. For example, childhood conflicts about sex and about her relations with her mother may have led to insecurity in the woman's feelings about her own femininity and about her capacity one day to become an effective mother herself. She may have dealt with the whole complicated issue by pushing it away into her unconscious, and by remaining an immature childlike person who avoids the dangers of the adult feminine role. The revival of the conflict during pregnancy gives her a second chance to work on it, and she may be able to come to terms with her mixed feelings, especially inasmuch as she probably has more strength of personality



than she had as a child, and in reality is not in the vulnerable position of being dependent on her mother. She also has social sanction to satisfy her sexual desires with her husband.

Experience teaches us that many pregnant women spontaneously mature, especially in their first and second pregnancies.

*Can the revival of old problems lead also to unhealthy results?*

Unfortunately the revival of these conflicts does not guarantee a better solution than in the past. The special hazard is that as the pregnant woman is psychologically preparing for her future baby and is at the same time preoccupied with old conflicts, she may intertwine the two, and use her baby vicariously as a means to solve her former problems. For example, if she has not been able to come to terms with her guilt feelings about adolescent masturbation and what this has meant to her in terms of her relationship with her parents, she may become convinced that she should be punished by damage to her sexual organs and to the baby. She may then develop not only the fear but the unconscious wish that her baby will be damaged in order to relieve her guilt. This will distort her expectations of the child and her way of handling him.

Another pattern that is not uncommon is for a woman—who has not resolved her mixed feelings toward her mother and who has not come to terms with her guilt for her hate and rebelliousness as a child—to work out the drama with her own child. She unconsciously identifies the child with her old “bad” self as a child, and she now plays the role of her own mother. The stage is thus set for her child to do to her what she did to her mother. As a matter of fact, her mother, when she was at her wits’ end in the face of her child’s provocation, may once have threatened that this would happen. She may have said, “Wait till you have a little girl—she will treat you as badly as you are treating me now—and that will be your punishment.”

The danger in this case, as in the previous example, is that the mother may unconsciously manipulate her child to play a part in a restaging of the old drama. This means that the mother does not perceive the child as a person in its own right, and the child does not have the freedom to live its own life. Child psychiatrists are familiar with this situation as an etiological factor in many of the mentally disordered children they treat. The origins of the disturbance can often be traced back to the mother’s pregnancy. (See *Childhood Emotional Disorders*)

***What can be done during pregnancy to prevent the origin of disturbed mother-child relationships, and to promote the maturation of the expectant mother's personality?***

Obstetricians, family doctors, nurses, nutritionists, and social workers, who take care of pregnant women, should collaborate with mental health specialists and learn how to identify those patients who are in danger of finding unhealthy solutions of their revived conflicts. They should give these patients extra support, and help them directly and through their families to keep their developing relationship with their future babies separate from the old problems. They should also help them to reevaluate themselves in the female role and as prospective mothers, and aid them in increasing their acceptance of themselves in these roles; and in this way improve their self-respect. Although pregnancy in itself is not an emotional crisis, it is a psychobiological transitional period in which intercurrent emotional crises are frequent, and it shares with all such periods the increased need for help and the susceptibility to influence by helping persons. This means that the doctors and nurses will be much more effective in helping a woman when she is pregnant than at other more stable periods of her life, and they can do a great deal to tip the balance in a healthy direction.

In difficult or resistant cases, the mental health specialists can be called in to intervene either directly with the patient and her family or to offer mental health consultation to the other professionals, so that they may be more effective in handling this and similar future cases.

***What about complications in the woman's relationship with her husband?***

The psychological changes of pregnancy are a problem not only for the woman but also for her husband and for her children. The expectant mother's mood changes, her sensitivity and irritability, her sudden changes in sexual desire and performance, and her increased need for love and attention are likely to upset her husband, who, in addition to everything else, may fear that she has developed unwelcome personality traits that may persist in the future. He may fear that if he "spoils" her as she demands, he will have to continue doing this indefinitely.

The husband's burdens are increased by the fact that the role of "expectant father" is not regarded too sympathetically in American culture. He is often the butt of jokes, especially at the time of childbirth.

Moreover the birth of a baby, especially the first, is likely to complicate his previous relationship with his wife. In a way, he will in the future have to compete with the baby for her attention. This is not an easy situation for some men to master.

These complications sometimes lead to marital friction. The husband may turn away from his wife just at the time she needs him most. Especially because of the sexual privation, he may turn to other women for satisfaction, and serious marital disunity may ensue.

*How can these difficulties be remedied?*

The obstetrician, and in difficult cases, other professional workers who are caring for the pregnant woman should routinely extend their help also to her husband. Early during the pregnancy, he and his wife together should be warned about the psychological complications that may arise. He should be reassured that they are normal reactions, and not signs of mental illness, and that they are temporary in nature. His aid in helping his wife during pregnancy should be actively enlisted, and the importance of his role as the expectant father should be recognized. In fact, studies have shown that a healthy mother-child relationship is more likely in a woman whose husband actively supports her during pregnancy and satisfies her cravings for increased love and attention, than in a woman who feels deprived.

Contact should be maintained with the father during the rest of pregnancy and during delivery, and proper respect should be accorded his role. Some fathers will need reassurance that in taking over part of their wife's role in housework and in caring for the children during pregnancy they are not behaving in an unmanly way.

*Is the pregnant woman likely to prefer her mother's attention rather than her husband's?*

Most pregnant women turn to their husbands for increased demonstrations of affection during pregnancy, but many also turn to their mothers, and some prefer the latter to the former. The preference for the mother over the husband may be due to the woman's realization that what she craves is a nurturing type of love that she has received in the past from her mother, rather than the erotic kind of love she associates with her husband. Moreover, as she prepares herself to assume the maternal role, she identifies with her mother and feels a closer bond to her than in the past. This situation need not lead to any special problem, since both husband and mother are likely to

understand and agree to what is happening. Occasionally, where the previous relationship between the woman and her family has been disturbed, her mother may resent the extra demands upon her affections and be rejecting, or the husband may feel jealous because he sees himself being passed over by his wife. The increased dependence of the woman on her mother may also lead to difficulties after the birth of the baby, either because the grandmother may be tempted to play too central a role in its care, or because she may feel rejected when the daughter's dependence upon her changes rather suddenly to a wish for independence in taking care of the child.

*Are there likely to be difficulties with children during their mother's pregnancy?*

The pregnant woman's irritability and depressions, and especially her change from being an outgoing giving person to becoming someone who is withdrawn and demanding, if not controlled or counteracted by the woman, are usually quite burdensome for her children. If the husband cannot step into the breach and help nurture the children at times of special difficulty, or if the mother's mother or some other female relative cannot help, a vicious circle is sometimes set up. The children may react to their mother's withdrawal by feeling deprived and by becoming more demanding of attention. Their increased demands upset the mother because of her irritability and introversion, and she may withdraw still further, which aggravates the situation even more.

The pregnant woman's children may be upset by the physical changes in her body, especially if they have not been given a satisfying explanation of what is happening, and they may develop fearful or jealous fantasies about the coming baby. Particularly difficult is the not uncommon situation where they are not told anything about the pregnancy directly, but overhear the adults talking, and fill in the information gaps out of their own vivid imaginations.

*How can these problems be handled?*

Those who care for the pregnant woman, and those who supervise the welfare of her children (pediatricians, teachers, and others), should pay attention to these matters. The husband and female relatives should try to provide the children with some of the nurturance their mother is temporarily unable to give. Extra attention to the children by the professional workers may also help a little. The parents should be

guided and supported in giving the children information about the pregnancy consonant with their capacity to understand what is involved. The parents should also be helped to understand the reactions of the children to the inevitable frustrations, so that they do not misinterpret the children's behavior as "pure naughtiness" or as some form of abnormality.

***What is a miscarriage? What causes it?***

A miscarriage is the premature delivery of the product of conception before the embryo becomes viable, i.e., before the embryo develops into a living fetus. After that stage we talk not of a miscarriage, but of a premature delivery. The possible causes of a miscarriage include faulty development of the fertilized ovum and the embryo, congenital abnormalities or diseases of the reproductive tract, hormonal imbalances or deficiencies, and physical injury to the embryo or the reproductive tract produced by instruments or drugs. Sometimes miscarriages may be psychologically induced as psychosomatic responses to emotional conflicts—particularly unconscious rejection of the baby or of the maternal role. Repeated miscarriages are produced by continuation of any of the above conditions, particularly by congenital abnormalities, hormonal deficiencies, and emotional conflicts. (See *Abortion*)

***What are the significant psychological reactions of women during childbirth?***

In American culture, childbirth is still, for many, a frightening experience, especially on the first occasion. The woman is separated from her family and, perhaps for the first time, goes into a hospital. There she is exposed to new and sometimes unpleasant sights and sounds, and often to the discomforts of injections and anesthetics. In addition there is the pain and discomfort of labor and delivery, and the concern about her own safety and that of her child. To offset all this is the pleasurable excitement that at last the end of pregnancy is in sight, and that the long-awaited baby will shortly appear. During the actual childbirth most women forget about all these things and restrict their interest and energy to themselves and what is happening to them.

***Do most women fear labor? Why?***

Some fear of labor is common among pregnant women, although it varies in degree according to the personality of the woman, the

culture of her group, and the type of psychological support she has received during pregnancy from her family and from her doctors and nurses. With some women the main factor is the fear of pain, or of the discomfort of anesthetics, or of hospital procedures. Especially in the first pregnancy there may be the fear of an unknown experience about which the woman may have heard frightening tales.

Labor involves a certain risk to life. The advances of modern obstetrics have reduced this risk tremendously, but some women are nevertheless frightened that they may die in childbirth. This fear is usually not just based on the risk, but is more commonly an irrational phobia linked with unconscious guilt and fantasies of expected punishment associated with childhood conflicts, such as those related to sex and masturbation or to naughtiness and rebelliousness against parents or to rivalry with siblings. Unconscious expectation of punishment due to repressed guilt may also lead to the fear of giving birth to a monster or a deformed baby, and this in turn may lead to a fear of labor.

***Should the husband participate in the labor experience?***

General rules and prescriptions on this topic are unwise. Some husbands may feel comfortable when participating in the early stages of the labor experience, and can be of help in offering emotional support to their wives. Many husbands are likely to feel quite tense and uncomfortable when participating in what they believe to be a woman's affair, and their discomfort is likely to be perceived by their wives, who may feel called upon to reassure them at a time when they themselves should be the recipients of care and support. Hospitals that cooperate in the "natural childbirth" method often encourage the husband's participation. If the husband does not feel too uncomfortable in this unaccustomed role, he benefits from the opportunity of being an active helper during a period when he would otherwise feel anxious about his wife's welfare, and passively useless. Most husbands in American culture are likely to feel upset by being present at the delivery, and are likely to get in the way of the doctors and nurses, either by their physical presence or by their emotional reactions.

***What can be done to help women handle the psychological problems of childbirth?***

They can be prepared in advance by being told in detail what is likely to happen, what they will see and hear and smell and feel, and

how they may best handle themselves. The latter cannot be prescribed, but women can be helped to prepare themselves ahead of time so that they can gain some degree of mastery over their concerns and insecurities, so that when the events take place they can recognize and understand them. They can also prepare physically by exercising some of the muscles that they will use during delivery, and by learning how to relax properly so as not to impede the birth process and tire themselves unduly during labor.

***Should the husband be prepared in advance about pregnancy and childbirth?***

Certainly. He should be involved as much as possible as an active partner in order that he may prepare himself adequately to assume the parental role, and in order that he may provide his wife with the extra emotional support she needs and with assistance in running the household and caring for the other children.

***What is natural childbirth?***

Some obstetricians think that the pain of childbirth, which is common in American culture, is mainly due to unhealthy expectations and fears, and to the inability of the woman to control the voluntary muscles of the lower part of her body. Moreover, they feel that it is important for a woman to be conscious throughout labor and actively to participate in the birth process, so that she is "present" when her baby first appears. They feel this is important as a basis for a healthy mother-child relationship. Therefore, they oppose the administration of an anesthetic to dull the pain of delivery, and instead they train the expectant mother physically and mentally so that she can go through childbirth without fear and tension, and with the necessary muscle control so that she has little or no pain.

For some women such a regime is highly acceptable, and childbirth indeed becomes a "wonderful experience." Other women either are unable to satisfy the training requirements, or are unable to accept the scientific or psychological basis of the regime. Most psychiatrists do not agree that the conscious "presence" of a woman during the birth of her baby is necessary for a healthy mother-child relationship. Most women have a time lag of a few days to a few weeks between birth and the development of a full relationship to their babies. It may be that this time lag is a little longer if the baby was delivered under anesthesia, but

this does not seem very important compared with all the other factors influencing the relationship. Women who have a long time lag develop just as good relationships to their babies as those with shorter time lags.

Finally, few psychiatrists accept the thesis that the pain of childbirth is mainly due to voluntary muscle tension. The fact that women who have been trained in "natural childbirth" have little or no pain does not prove the thesis, since consciousness of pain is quite susceptible to suggestion; for example, hypnosis can be just as effective in preventing the pain of childbirth.

***Do special mental illnesses occur during pregnancy or immediately following childbirth?***

Mental illnesses sometimes occur in pregnant women, and sometimes follow childbirth, but they are exceedingly rare. They have no special characteristics, but are similar to illnesses that occur at other times, e.g., schizophrenia, manic-depressive psychosis, etc. It is possible that the physical changes or the stresses of this period may be contributing factors in their causation, but it may also be that they occur at this time rather than at another period in the lives of these women mainly by chance. There is no evidence that these illnesses are related to the common psychological manifestations that have been described in this article.

***What is postpartum depression? What causes it?***

As its name implies, this is a mental disorder that sometimes occurs in women after childbirth, usually within a few weeks after delivery. The chief manifestations are feelings of hopelessness, misery, unworthiness, insomnia, loss of appetite, excessive anxiety about the baby and its care, and sometimes thoughts of suicide or of harming the child. We have no sure knowledge of the causes of this condition, although it is likely that the physical stress and fatigue of labor and delivery may be a contributory factor, just as deep psychological conflicts about becoming a mother may be. If no treatment is provided, the condition usually resolves itself within a few weeks to several months, although occasionally it may last for a longer period.

Treatment by a psychiatrist is usually necessary. Occasionally the patient may have to be admitted to a hospital in order to safeguard against the danger of suicide. Milder cases usually respond favorably to psychotherapy. Antidepressant drugs are often of benefit, and if these measures fail, electroshock therapy will usually hasten recovery.